		AND HUMAN SERVICES				FORM	07/09/2013 APPROVED 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		146067	B. WING			04/	18/2013
NAME OF PROVIDER O	R SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA NURSING	G AND REH	AB CENTER			101 EAST STATE STREET ENEVA, IL 60134		
PREFIX (EAC	H DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Director Houseke was obs records boxes. sides with Right ab This me activated soaked of fire, the type of f fire or ar Interview of Nurse say the f on the c for resid 2011. F9999 FINAL C Licensu 300.121 300.122 300.324	eeper) the i erved. The noted on si The shelve the no prote ove the sh aning if the d, the clinic with water si clinical rec re resistan ny other typ with E1 (// si) on 4/10/ facility does omputers f ents that w DBSERVAT re Violation 0b) 0d)6) 0b)3) 0a)	Administrator) and E2 (Director 13 at 4:30 p.m. noted both to 5 not have a back up system or residents' clinical records and/or destroyed. In case of a both were not stored in any tiles to protect them against be of mishap. Administrator and E2 (Director 13 at 4:30 p.m. noted both to 5 not have a back up system or residents' clinical records are discharged before July TONS	F9	516			

If continuation sheet Page 47 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		146067	B. WING			04 / [.]	18/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
GENEVA	NURSING AND REH	AB CENTER			101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 47	F99	999			
	and services to atta practicable physical well-being of the res each resident's com plan. Adequate and care and personal c	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident.					
	Section 300.1210 G Nursing and Persor	General Requirements for nal Care					
	assure that the residual as free of accident I nursing personnel s	ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see eceives adequate supervision revent accidents.					
	Section 300.1220 S Services	Supervision of Nursing					
		upervise and oversee the the facility, including:					
	3) Developing an up	p-to-date resident care plan for					

		HAND HUMAN SERVICES				FORM	07/09/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	E SURVEY PLETED
		146067	B. WING	;		04 / [.]	18/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA	NURSING AND REH	AB CENTER			1101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	and goals to be acc and personal care a representing other s activities, dietary, and are ordered by the the preparation of the plan shall be in write modified in keeping indicated by the res	-	F9	999			
	Section 300.3240 A	Abuse and Neglect					
		ee, administrator, employee or hall not abuse or neglect a					
	These Regulations by:	were not met as evidenced					
	interview the facility 2 residents' falls to falling and sustainir residents (R12 and	ion, record review, and / failed to assess and analyze prevent the residents from ng injuries. This is for 2 R11) in the sample of 17.					
	and sustained skin	ailure R12 had several falls tears and was hospitalized re at L4. As a result of this					

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		AND HUMAN SERVICES				FORM	07/09/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		146067	B. WING	;		04/	18/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA	A NURSING AND REH	AB CENTER			1101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	failure R11 had a fa to the back of her h and insertion of 6 s The findings include 1. Review of R12's R12 is an 86 year of which included Alzh the facility's inciden fall incidents from 1 report documentation 10/38/12 - 3:45 p.m (no specific area do lower forearms. (N treatment document 11/18/12 - 11:40 a.t injury. 3/22/13 - 3:30 p.m. next to bathroom do Steri strips applied. also showed R12 is transfer and toilet s independent mobilit Review of nursing of at 9:07 p.m. showed supper and compla needed) medication documentation in th (Medication Admini medication was given med, etc).	all and sustained a laceration head which required an ER visit taple sutures. e: admission face sheet showed old resident with diagnosis heimer's Disease. Review of it reports showed R12 had 3 l0/28/12 to 3/22/12. Incident on showed the following: h Found on floor in hallway bocumented). Skin tear to right lo size, length, description, or hted). m On floor in bathroom. No - Found laying on right side oor. Skin tear to right arm. Incident investigation report s noted to frequently self but resident has impaired		999			

If continuation sheet Page 50 of 61

		AND HUMAN SERVICES				FORM	07/09/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		146067	B. WING	i		04 / [.]	18/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA	A NURSING AND REH	AB CENTER			101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	at 10:25 p.m. show CNA (Certified Nurs resident was comple When assessed, re- dinner and upon mo- out and stated he w ER per MD. Reside Further review of nu- showed no pain me- R12 being sent to E screaming out in par Review of hospital I dated 3/29/13 show hospital on 3/26/13 of pain. Physician I R12's MRI showed compression fractu Physician Discharg found to have comp of his pain which re (narcotic pain medi to the facility on 3/2 Observation of R12 R12 to be resting in this time noted R12 back here. I injured re-injured it here. I have to take too mu- the bathroom and fa- Since two of R12's attempting to go to of care was reviewed initiated to decrease plan of care showed	ed, "Upon arriving on shift ses Aide) on duty reported that laining of lower back pain. esident refused to get up for ovement resident screamed vanted to die. Ok to sent to ent admitted for back pain." urses notes and R12's MAR edication was given prior to ER, even though R12 was ain. Physician Discharge Summary ved R12 was admitted to the for pain control and evaluation Discharge Summary notes R12 with a L4 vertebral re. Further review of the e Summary showed R12 was pression fracture as the cause equired IV morphine and Norco cations). R12 was readmitted 29/13. C on 4/10/13 at 2:30 p.m. noted h bed. Interview with R12 at 2 to say, "I fell and hurt my d it a long time ago but I was taking pain meds. I don't uch med now. I tried to go to	F99	9999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/09/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		146067	B. WING	÷		04/ ⁻	18/2013
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA	NURSING AND REH	AB CENTER			101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F9999	toileting program R should be toileted, w etc Interview with E4 (F 4/11/13 at 11:50 a.r toileted every 2 hou E4 was asked abou for residents in the responded, "I don't assessment of the I contact the staff for them about the resi not assess the resid incontinence a resid stress, functional, e did not assess and identitying that R12 the bathroom. E4 a identify that 2 of R1 3/22/13) occurred w (3:30 p.m. and 3:45 Further review of R interventions to eva gather and assess (2) R11 is a 85 year including: Dementi a history of Fracture previous fall. Review of the facilit	And the specific as to what type of 12 was on, how often R12 when R12 should be toileted RN - Restorative Nurse) on m. noted E4 to say, "R12 is the save the paper work for the Bowel and Bladder programs. F4 save the paper work for the Bowel and Bladder programs. F3 consecutive days and ask dent." E4 admitted she does dents to identify the type of dent has (such as mixed, tc). E4 also admitted she or analyze R12's falls had falls attempting to go to also admitted she did not 2's falls (10/28/12 and within 15 minute timeframes 5 p.m.).	F9!	999			

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		AND HUMAN SERVICES				FORM	07/09/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		146067	B. WING	3 <u> </u>		04/	18/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA	NURSING AND REH	AB CENTER			1101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 52	F9	999	9		
	dated 11/11/2012 d "Observed patien side. Back of head dressing applied." and required appro- laceration to the bar The Investigation R documented R11's	sual Occurrence Report Form, locumented the following: t (R11) laying on patient's opened and pressure R11 was sent to the hospital ximately 6 staple to close her ck of her head. Report, dated 11/12/2012, incident, but it did not analyze about her fall that caused her					
	4/09/2013 at 1 PM. completing resident that R11 had mats 11/16/2012. E4 con sustained a lacerati she landed on the r good question Its have hit the dressed	se, E4, was interviewed on E4 said she is responsible for t's fall investigations. E4 said on the floor when she fell on uld not explain why R4 ion to the back of her head if mattress. E4 replied, "That's a s possible she (R11) could r or side rails." However, a of R11's fall was not done.					
		(B)					
	300.610 a) 300.610c)2 300.2100						
	750.110 c) 750.110 k) 5						

Facility ID: IL6003503

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	-	AND HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(V2) MU		PLE CONSTRUCTION		0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			G		PLETED
		146067	B. WING)		04/	18/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA	NURSING AND REH	AB CENTER			1101 EAST STATE STREET		
					GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From no	ao 50	F 0/	~~~			
F 9999	Continued From pa 750.110 I)	ye bo	F99	995	9		
	750.180 b)						
	Section 300.610 Re	esident Care Policies					
	a) The facility shall	have written policies and					
	procedures governi	ng all services provided by the					
		policies and procedures shall Resident Care Policy					
	Committee consisti	ng of at least the					
		dvisory physician or the					
		ommittee, and representatives r services in the facility. The					
	policies shall compl	y with the Act and this Part.					
		shall be followed in operating be reviewed at least annually					
	by this committee, o	documented by written, signed					
	and dated minutes	of the meeting.					
	c) The written polici	es shall include, at a minimum					
	the following provisi	,					
		rvices, including physician					
		cy services, personal care and					
		estorative services, activity eutical services, dietary					
	services, social services	vices, clinical records, dental					
	services, and diagn laboratory and x-ray	ostic services (including /):					
	,						
		ood Handling Sanitation comply with the Department's					
		Service Sanitation" (77 III.					

If continuation sheet Page 54 of 61

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/09/2013 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		E SURVEY PLETED
		146067	B. WING)		04 / ⁻	18/2013
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 1101 EAST STATE STREET		
GENEVA	NURSING AND REH	AB CENTER			GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa Adm. Code 750).	ge 54	F99	999	9		
	Section 750.110 Sp	ecial Requirements					
	intact and without c pasteurized liquid, p frozen, or pasteuriz used, except that ha	e Grade A eggs, with shell racks or checks, or basteurized shell, pasteurized ed dry egg products shall be ard-boiled peeled eggs, red and packaged, may be					
	primary consumers individuals, such as day care centers ar	vice establishments whose are highly susceptible nursing homes, hospitals, id nursery schools, shall not cooked animal foods (see					
	substituted for raw of foods such as Caes bearnaise sauce, m eggnog, ice cream, that are: 1) Not properly cool for 15 seconds for s prepared in respons for immediate servi 2) Not properly cool	ked to 155°F (68°C) or above shell eggs that are not					

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		146067			04	/18/2013
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP (•	10/2013
GENEVA	NURSING AND REH	IAB CENTER		1101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F9999	Continued From pa 3) Not included in a described in subse	a consumer advisory as	F99	99		
	Section 750.180 C Foods	ooking Potentially Hazardous				
	served or offered fe are exempt from the subsections (a)(1) provided the food e follows the consume specified in Section type of food include molluscan shellfish fish; rare meat; and Establishments such hospitals, day care that serve a highly including the elder four, pregnant worn or have compromis serve raw or under	cooked animal foods that are or sale in a ready-to-eat form he cooking requirements of through (5) of this Section, establishment serving the food her advisory requirements in 750.110(j). Examples of this e raw marinated fish; raw it; steak tartare; lightly cooked d soft cooked eggs. ch as nursing homes, centers and nursery schools susceptible population, y, young children under age nen, and individuals who are ill sed immune systems, shall not cooked animal foods, or must ctions (a)(1) through (5) of this				
	These Regulations by:	were not met as evidenced				
		ion, interview and record ailed to use appropriate				

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 146067 B. WING 04/18/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1101 EAST STATE STREET GENEVA NURSING AND REHAB CENTER** GENEVA, IL 60134 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 56 F9999 methods to prepare and serve potentially hazardous food for two residents (R1) and (R2) who were served unpasteurized fried, shell eggs that were not cooked to a safe temperature that would congeal the volks. R1 and R2, who requested fried eggs, are considered to be in a highly susceptible population; immunine compromises, and at risk for the development of food borne illness (Salmonella). R2 was observed in the first floor dining room with over easy fried eggs on her breakfast plate. The yolks were runny as R2 has requested. E13 Registered Dietitian (RD) consultant verified that the facility did not use pasteurized shell eggs. R1 was also served a fried egg at this breakfast meal. The breakfast plates for R1 and R2 were removed from their breakfast tables and shown to E1 Administer, E5, Dietary Supervisor, and E13, and three members of the survey team. Part of the liquid volk remained pooled around the bottom of the plate. The dietary policy was changed to indicate only pasteurized shell eggs will be used for any item that is not thoroughly cooked, the unpasteurized eggs were discarded, dietary staff was trained, pasteurized eggs were purchased for the breakfast meal on 4/9/12.. This applies to two residents R1 and R2 in the sample of 18. Findings include. The breakfast meal was observed in preparation and service on 4/8/13 to include juice, cereal, egg and sausage casserole, toast and milk. R1 and R2 were served fried eggs per their request. The

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	07/09/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DATE	E SURVEY PLETED
		146067	B. WING	÷		04 / [.]	18/2013
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GENEVA	NURSING AND REH	AB CENTER			1101 EAST STATE STREET GENEVA, IL 60134		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	dietary cook E24 sa residents who have The facility recipe for sheet pan should be hot, take eggs from sheet pan. Bake 15 internal temperature Unpasteurized eggs response to resider promptly after cook internal temperature IF UNPASTEURIZE MUST BE COOKEI COOMPLETELY SI CONGEALED. The interpretative g Appendix P the stat Some foods are con others and are calle "potentially hazardo Time/Temperature food. Examples of f ground beef, poultry shellfish), cut melor yogurt and cottage Unpasteurized eggs response to resider	aid that these are the only two e asked for fried eggs. or Fried eggs indicates that a e place in a 350 F. oven until a refrigerator and crack on to 5 minutes (eggs should be at e of 155 for 15 seconds). s when cooked to order in at request and to be eaten ing shall be cooked to an e of 145 for 15 seconds ED EGGS ARE USED, EGGS D UNTIL THE WHITE IS ET AND YOLK IS guidelines under F371 in te operations manual state: nsidered more hazardous than ed bus foods (PHF) or Controlled for Safety (TCS)" PHF/TCS foods include y, chicken, seafood (fish or n, unpasteurized eggs, milk, cheese. s when cooked to order in at request and to be eaten	F9	99%			
	seconds; until the w yolk is congealed;	ing; - 145 degrees F for 15 white is completely set and the Sanitation Code, 2008 77 III. Ite the following:					

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TATEMENT	OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		146067			04	/18/2013
	ROVIDER OR SUPPLIER	AB CENTER	1	STREET ADDRESS, CITY, STATE, ZIP CC 1101 EAST STATE STREET GENEVA, IL 60134	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETIC DATE
F9999	Continued From pa	age 58	F99	999		
	that serves a highly following criteria ap b) Pasteurized egg substituted for raw foods using raw or Time only, as the p under Section 750. eggs. (Source: Added at July 10, 2008). Th definition of: "Highly susceptible who are more likely general population disease because th preschool age child Obtain food at a fa such as custodial of living (such as a ch kidney dialysis cen or nutritional or soo senior center). Review of R2 's ac 1/24/2013 shows s diagnosis including	as or egg products shall be eggs in the preparation of undercooked shell eggs. c) public health control specified 153, may not be used for raw 32 III. Reg. 11980, effective is code also includes the population" means persons y than other people in the to experience food-borne hey: Are immunocompromised, dren or older adults; and cility that provides services care, health care, or assisted hild or adult day care center, ter, hospital or nursing home), cialization services (such as a				
	disease, hypertens pulmonary disease her room at 11:30a likes her eggs fried days. She likes the her toast into it. R	asthma, chronic kidney ion and chronic obstructive . During an interview with R2 im on 4/8/13 R2 said she only , and she eats them most yolks runny so she can dip 2 ' s tray card placed at her preakfast meal fried egg only.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB										
	OF DEFICIENCIES		(X2) MU	LTIP		MB NO. 0938-0391 (X3) DATE SURVEY				
-	F CORRECTION	IDENTIFICATION NUMBER:			G	COMPLETED				
		146067	B. WING			04 / [.]	18/2013			
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
GENEVA	NURSING AND REH	AB CENTER			1101 EAST STATE STREET GENEVA, IL 60134					
	SUMMARY STA		ID		PROVIDER'S PLAN OF CORRECTION		(VE)			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFUNATION)		PREF TAG	IX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE			
TAG	REGULATORT ON L	REGULATORY OR LSC IDENTIFYING INFORMATION)		j	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)					
F9999	Continued From page 59		F9999		9					
	R1 's admission re	cord dated 2/21/13 that she is								
	an 83 year old with	diagnosis including end stage								
		becified heart failure and								
	diabetes. R1 ' s care plan (not dated) with a target date of 7/6/13 indicates she receives renal									
	hemodialysis three	times a week.								
	(B)									
	300.3060a)4)									
	Section 300.3060 Nursing Unit									
	a) General Requirements for Bedrooms									
	4) A closet or wardrobe at least four square feet									
	shall be provided for each re	esident								
	This Deculation wa	s not met as evidenced by:								
	This is guiddon was	S HUL MEL as Evidenced by.								
	Deced an obconveti	in and interview the facility								
		ion and interview the facility equate space for storing								
	resident clothing by	ensuring resident rooms had								
		hat was at least four square								
	feet.									
	The findings include	e:								
	On 4/10/13 at 9:50	a.m. during the General								
		Facility with Z1 (Maintenance								
			l I							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB											
STATEMENT OF DEFICIENCIES (X1) PROVID	DER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
	146067	B. WING			04/18/2013						
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 101 EAST STATE STREET								
GENEVA NURSING AND REHAB CENTE			GENEVA, IL 60134								
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PF TAG REGULATORY OR LSC IDENTIFYI	RECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE					
F9999 Continued From page 60 Director from another facility) Housekeeper), resident room observed. All resident room observed to be very small. Measurement of the residents either 22 x 21 inches or 22 x 22 (approximately 2 square feet). Interview with E1 (Administrat 10:00 a.m. noted E1 to say all rooms have the same closet, are the same size and measu square feet.	and E14 (Lead closets were closets were s closets measured 22 inches for) on 4/12/13 at l of the resident so all of the closets	μ	999	DEFICIENCY)							

Facility ID: IL6003503

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