	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		14E572	B. WING			R	
	OVIDER OR SUPPLIER	172072		TREET ADDRESS, CITY, STATE, ZIP CC	01/22/2015		
				600 WEST GOLF ROAD			
SKOKIE M	EADOWS NURSING CE	NTERII		KOKIE, IL 60076			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	COMPLETION	
{F 000}	INITIAL COMMENTS	3	{F 000}				
	First Certification Re	visit To Survey Date 12/8/14					
{F 226} SS=E	483.13(c) DEVELOPA ABUSE/NEGLECT, E	/IMPLMENT	{F 226}				
	policies and procedur	t, and abuse of residents					
	by: Based on interview a failed to educate staff and the location of po facility also failed to fo prevention program. The findings include: On 1/21/2014 at 10:5 Nurse Assistant) state to his supervisor and another number to ca	i0am, E12 CNA (Certified es he would report a crime he was not aware of all if there was a crime. E12					
	specifically on reporti On 1/21/2014 at 11:0 has not receive in-se after October 2014. E local police if she with On 1/21/2015 at 11:0 states she was not al as yet on the reportin On 1/22/2015 at 11:0	Oam, E13 (Nurse) states she rvice on report of a crime E13 states she would call the nessed a crime. I3am, E1 (Administrator) ble to get all staff in-serviced					
	reporting of a crime.	sign in sheet for reporting of					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/20 FORM APPROVE OMB NO. 0938-039
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		R 01/22/2015
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
{F 226} {F 248} SS=D	employee signatures, employees showed a currently works with t The facility 's undate Prevention Program I Orientation and Train that staff will receive s obligation under the suspected crime to th agency and local law 483.15(f)(1) ACTIVIT INTERESTS/NEEDS The facility must prov of activities designed the comprehensive as	hat all shift / all shift list 39 . Facility ' s current list of all list of 55 employees that he residents directly. d policy on Abuse Facility Procedures 111 ing of Employees showed a review ofan employee ' e law for reporting a he facility, the state survey enforcement IES MEET	{F 226		
	by: Based on observatio review the facility faile failed to modify activi preferences and abili (R4 and R6) in a sam Findings include: R4 is a 62 year old re bipolar disorder and o pain. R4 recently cor improve his strength blood vessel in the R 12/19/14, an order wa				

If continuation sheet Page 2 of 27

		MEDICAID SERVICES					APPROVED . 0938-0391
STATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		14E572	B. WING		_		२ 22/2015
NAME OF PROVIDER	OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SKOKIE MEADOV	VS NURSING CEI	NTER I I		1600 WEST GOLF ROAD SKOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
R4 wa the fac of biki E11 (F that R Thurs 1:30- gone y 1/21/1 gone f so far :"It is a and re still ha docum stated anywh order a curr The o month attence	cility but not goin ing. PRSD) provided 44 should attend day, and Friday 2pm. E11 state yet. E18 (PRS) 15 at 11:10am, a to biking. E18 s . E18 was aske a relatively new eminded him sev as not." E18 was nented these inv that she had no here. E10 (nurs regarding the bi rent order. rder has been p n without any as this biking activ	roup meetings and around ng for his scheduled activity a schedule that indicated biking on Monday, . He is scheduled from d that she knew he had not C) was interviewed on about how often he has tated that he had not been d why and responded that order. I have invited him veral times to come, but he s asked if she has vitations in the past. E18 ot documented this e) was asked to confirm the ke. E10 stated that it is still resent for more than a sessment or care plan to	{F 248}				
being and a state t e/b (e expre- transn rarely comm	Bipolar had a ca revised care pla that R6 is cognit videnced by) po ssing himself, pr nission of inform socializes with unication skills.	as having head trauma and are plan dated 10/14/2014 an dated 1/13/2015 that both ively impaired; problem is or memory, difficulty roblems with reception and nation. Both plans state he others d/t (due to) poor stated: R6 will improve					

If continuation sheet Page 3 of 27

		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/26/2019 FORM APPROVED MB NO. 0938-039
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		DNSTRUCTION	()	X3) DATE SURVEY COMPLETED
		14E572	B. WING _				R 01/22/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	
	IEADOWS NURSING CE	NTERII		4600) WEST GOLF ROAD		
				SKC	OKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
{F 248}	in the facility activities review date. Since th December 8, 2014, R attending community on 12/30/14; Bingo of meeting on 1/20/2019 The facility's One-to-(purpose as: to provid resident with specific not appropriate for gr medical, behavioral a withdrawal, mood sta His documented 1:1 if on 12/26/14; 1/9/15; Care plan intervention program of activities resident's abilities like parties and social eve (bingo/pokeno) that F	tive function by participating s at least 2 x/day through the he plan of correction dated 86 is documented as meeting on 12/23/14; Bingo n 1/13/15; Community 5. One Protocol states the de a personalized forum for psychosocial need who a roup intervention due to and/or extreme psychosocial ite-related problems. interventions only occurred 1/16/15 and 1/21/15 ns include: Provide a that accommodates the e non-insight activity groups,	{F 2-	48}			
	correct application in R6 was observed in a 1/20/2015 sitting alor eyes closed while bin called out. When E1 R6, E12 (Certified Nu the bingo board for R R6. Witnessed by E- the bingo process is R6 would best benefit E-14 (Activity Directo and watches others w Pokeno and that E-14	ne with his head down and ago numbers were being 2 arrived and stood beside ursing Assistant) manipulated 6 without any involvement of 13 (PRSC) who agreed that very fast paced and stated					

If continuation sheet Page 4 of 27

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE C	ONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		· · ·	IPLETED
						R
		14E572	B. WING			1/22/2015
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CO	DE	
SKOKIE N	IEADOWS NURSING CE	NTERII		0 WEST GOLF ROAD OKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
{F 248}	Continued From page	e 4	{F 248}			
{F 280}	most. 483.20(d)(3), 483.10({F 280}			
(F 280) SS=D		NING CARE-REVISE CP	{F 200}			
	The resident has the incompetent or other	right, unless adjudged				
		he laws of the State, to				
	-	g care and treatment or				
	changes in care and t	treatment.				
	A comprehensive car	e plan must be developed				
	within 7 days after the					
	-	ssment; prepared by an				
		, that includes the attending d nurse with responsibility				
		other appropriate staff in				
		ined by the resident's needs,				
		cticable, the participation of				
		lent's family or the resident's and periodically reviewed				
		n of qualified persons after				
	each assessment.					
	This REQUIREMENT	is not met as evidenced				
	Based on observatio	n, interview and record ed to implement and revise				
	care plans for 2 reside	ents (R5 & R6) reviewed in				
	a sample size of 12.					
	Findings include:					
		an with a diagnosis of				
	Schizoaffective and o	•				
	disorders. On 1/21/1					

Facility ID: IL6008643

If continuation sheet Page 5 of 27

STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	10.0938-039 TE SURVEY MPLETED
						R
		14E572	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE		1/22/2015
NAME OF P	ROVIDER OR SUPPLIER			600 WEST GOLF ROAD		
SKOKIE N	IEADOWS NURSING CE	NTERII		KOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{F 280}	observed sitting on the community morning m interview, R5 stated to receive the coffee that the meeting, because When probed further, accidents when he ear R5 stated "I mess my some foods go right to leak, that is why I dor mess myself, I try to g smells, I don't like that clean." When asked states it happens at lear Discussions with the approximately 11:45a (Director of Nurses); I Nursing); E16 (Regist and unable to speak to experiencing incontin the nursing assistants living) documentation December 11, 2014 to no documentation of presence of E2, R5 w At that time, R5 resta incontinency with urin attempts to clean him help as needed. R5 in Nurse Assistant); E17 and E19 (Certified Nu assisted him. E19 co had periods of incontin recorded.	the back wall during the neeting. During the hat he did not want to at is rewarded for attending the may have an accident. R5 stated that he has at and drinks certain foods. The parts sometimes cause hrough me. I hate it when I at drink the pop." "when I get it off me cause my body at cause I am used to being how often it happens, R5 east a couple times a week. following staff at an showed that neither E2 E3(Asst. Director of tered Nurse) were aware to the frequency that R5 was ency episodes. Review of a ADL (activities of daily forms dated from o January 19, 2015 showed incontinency with R5. In the vas interviewed in his room. ted that he has period of the and bowel and that he a self and and has asked for identified E12 (Certified 7 (Certified Nurse Assistant) ursing Assistant) has onfirmed to E2 that R5 has inence that E19 has not	{F 280}			

Facility ID: IL6008643

If continuation sheet Page 6 of 27

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391			
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		14E572	B. WING				R 22/2015
NAME OF P	ROVIDER OR SUPPLIER		•	;	STREET ADDRESS, CITY, STATE, ZIP CODE		
					4600 WEST GOLF ROAD		
SKOKIEN	IEADOWS NURSING CE	NIERII		:	SKOKIE, IL 60076		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 280}	causes of incontinent to provide any docum 1/21/2015, the care p updates regarding the of R5. R6 is a 68 year old m trauma and Bipolar. R6 had a care plan date that R6 is cognitively (evidenced by) poor n himself, problems with transmission of inform rarely socializes with communication skills. The facility's One-to-O purpose as: to provid resident with specific not appropriate for gra- medical, behavioral a withdrawal, mood sta His documented 1:1 i on 12/26/14; 1/9/15; ⁻ Care plan intervention program of activities to resident's abilities like parties and social eve (bingo/pokeno) that R provoking and require number and apply the correct application in R6 was observed in a 1/20/2015 sitting alon eyes closed while bin	bort PRN any possible be. The facility was unable rentation at this time. As of lan does not reflect any e ongoing continence issues an diagnosed with head lated 10/14/2014 and a ed 1/13/2015 that both state impaired; problem is e/b nemory, difficulty expressing h reception and hation. Both plans state he others d/t (due to) poor One Protocol states the le a personalized forum for psychosocial need who a oup intervention due to nd/or extreme psychosocial te-related problems. nterventions only occurred 1/16/15 and 1/21/15 hs include: Provide a hat accommodates the e non-insight activity groups, ents. Activities 6 attends are thought e the ability to hear a card or e direction by making the a very short period of time.	{F 2	280}	}		

Facility ID: IL6008643

If continuation sheet Page 7 of 27

		ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		14E572	B. WING	 		२ 22/2015
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
SKOKIE M	IEADOWS NURSING CEI	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 280} {F 282} SS=D	the bingo board for Ri R6. Witnessed by E- the bingo process is w R6 would best benefit The facility Plan of Co states care plans will revised and updated l activity director, care supervisor quarterly/a revised based on thei goals will be validated interventions will be re effectivity. This did not occur for 483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by o accordance with each care. This REQUIREMENT by: Based on observation review the facility faile care plans for 2 reside a sample size of 12. Findings include: R5 is a 70 year old m Schizoaffective and o disorders. On 1/21/13	rsing Assistant) manipulated 6 without any involvement of 13 (PRSC) who agreed that very fast paced and stated t by having 1:1's. Direction dated 12/10/2014 be continuously reviewed, by each PRSC/PRSD, plan coordinator and dietary annually. Problems will be r current issues/problems, d if met/unmet and evised/changed based on R5 or R6. TICES BY QUALIFIED TE PLAN d or arranged by the facility qualified persons in n resident's written plan of f is not met as evidenced n, interview and record ed to implement and revise ents (R5 & R6) reviewed in an with a diagnosis of bsessive compulsion 5 at 9:47am, R5 was	{F 2	}		
	disorders. On 1/21/1	•				

Facility ID: IL6008643

If continuation sheet Page 8 of 27

IDENTIFICATION NUMBER: A BUILDING 14E572 B. WING SKOKIE MEADOWS NURSING CENTER I I STREET ADDRESS, CITY, STATE, ZIP COD (X4) /D PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CC (X4) /D PREFIX CACH DEFICIENT USE E PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PIC (F 282) Continued From page 8 community morning meeting. During the interview, R5 stated that he did not want to receive the coffee that is rewarded for attending the meeting, because he may have an accident. When probed further, R5 stated that he has accidents when he eat and drinks certain foods. R5 stated "I mess my pants sometimes cause some foods go right through me. I hate it when I leak, that is why I don't drink the pop." "when I mess myself. I try to get it off me cause my body smells, I don't like that cause I am used to being clean." When asked how often it happens, R5 states it happens at least a couple times a week. Discussions with the following staff at approximately 11:45am showed that neither E2 (Director of Nurses); E3(Asst. Director of Nursing); E16 (Registered Nurse) were aware and unable to speak to the frequency that R5 was experiencing incontinency episodes. Review of the nursing assistants ADL (activities of daily living) documentation forms dated from December 11, 2014 to January 19, 2015 showed no documentation of incontinency with R5. In the means of ECD DF unce therein the prime means	RRECTION (X5) SHOULD BE COMPLET
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD SKOKIE MEADOWS NURSING CENTER I I STREET ADDRESS, CITY, STATE, ZIP COD (X4) JD PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH ODREDFICIENCY WIDST EP RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG D PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION) (F 282) Continued From page 8 community morning meeting. During the interview, R5 stated that he did not want to receive the coffee that is rewarded for attending the meeting, because he may have an accident. When probed further, R5 stated that he has accidents when he eat and drinks certain foods. R5 stated "I mess my pants sometimes cause some foods go right through me. I hate it when I leak, that is why I don't drink the pop." "when I mess myself, I try to get it off me cause my body smells, I don't like that cause I am used to being cleam." When asked how often it happens, R5 states it happens at least a couple times a week. Discussions with the following staff at approximately 11:45am showed that neither E2 (Director of Nurses); E3(Asst. Director of Nursing); E16 (Registered Nurse) were aware and unable to speak to the frequency that R5 was experiencing incontinency episodes. Review of the nursing assistant ADL (activities of daily living) documentation forms dated from December 11, 2014 to January 19, 2015 showed no documentation of incontinency with R5. In the	RRECTION (X5) SHOULD BE COMPLETE
SKOKIE MEADOWS NURSING CENTER II 4600 WEST GOLF ROAD SKOKIE, IL 60076 [XM] ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH ORREDFICENCY WINGT FE PRECOED BY FULL (EACH ORREDTWEATION) D PREFIX TAG PROVIDER'S PLAN OF CC (EACH ORRECTW ACTION) {F 282} Continued From page 8 community morning meeting. During the interview, R5 stated that he did not want to receive the coffee that is rewarded for attending the meeting, because he may have an accident. When probed further, R5 stated that he has accidents when he eat and drinks certain foods. R5 stated "I mess my pants sometimes cause some foods go right through me. I hate it when I leak, that is why I don't drink the pop." "when I mess myself, I try to get it off me cause my body smells, I don't like that cause I am used to being clean." When asked how often it happens, R5 states it happens at least a couple times a week. Discussions with the following staff at approximately 11:45am showed that neither E2 (Director of Nurses); E3(Asst. Director of Nursing); E16 (Registered Nurse) were aware and unable to speak to the frequency that R5 was experiencing incontinency episodes. Review of the nursing assistants ADL (activities of daily living) documentation forms dated from December 11, 2014 to January 19, 2015 showed no documentation of incontinency with R5. In the	RRECTION (X5) SHOULD BE COMPLET
SKOKIE MEADOWS NURSING CENTER II SKOKIE, IL 60076 (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 CC (EACH CORRECTIVE ACTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION) (F 282) Continued From page 8 community morning meeting. During the interview, R5 stated that he did not want to receive the coffee that is rewarded for attending the meeting, because he may have an accident. When probed further, R5 stated that he has accidents when he eat and drinks certain foods. R5 stated "I mess my pants sometimes cause some foods go right through me. I hate it when I leak, that is why I don't drink the pop." "when I mess myself, I try to get it off me cause my body smells, I don't like that cause I am used to being clean." When asked how often it happens, R5 states it happens at least a couple times a week. Discussions with the following staff at approximately 11:45am showed that neither E2 (Director of Nursey); E3(Asst. Director of Nursing); E16 (Registered Nurse) were aware and unable to speak to the frequency that R5 was experiencing incontinency episodes. Review of the nursing assistants ADL (activities of daily living) documentation forms dated from December 11, 2014 to January 19, 2015 showed no documentation of incontinency with R5. In the ID	SHOULD BE COMPLETI
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the meeting, because he may have an accident. When probed further, R5 stated that he has accidents when he eat and drinks certain foods. R5 stated "I mess my pants sometimes cause some foods go right through me. I hate it when I leak, that is why I don't drink the pop." "when I mess myself, I try to get it off me cause my body smells, I don't like that cause I am used to being clean." When asked how often it happens, R5 states it happens at least a couple times a week. Discussions with the following staff at approximately 11:45am showed that neither E2 (Director of Nurses); E3(Asst. Director of Nursing); E16 (Registered Nurse) were aware and unable to speak to the frequency that R5 was experiencing incontinency episodes. Review of the nursing assistants ADL (activities of daily living) documentation forms dated from December 11, 2014 to January 19, 2015 showed no documentation of incontinency with R5. In the	
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living) documentation forms dated from December 11, 2014 to January 19, 2015 showed no documentation of incontinency with R5. In the	
December 11, 2014 to January 19, 2015 showed no documentation of incontinency with R5. In the	
no documentation of incontinency with R5. In the	
presence of E2, R5 was interviewed in his room.	
At that time, R5 restated that he has period of	
incontinency with urine and bowel and that he	
attempts to clean him self and and has asked for help as needed. R5 identified E12 (Certified	
Nurse Assistant); E17 (Certified Nurse Assistant)	
and E19 (Certified Nursing Assistant) has	
assisted him. E19 confirmed to E2 that R5 has	
had periods of incontinence that E19 has not recorded.	
R5's care plan initiated on 11/13/14 intervention states the following for R5:	

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 01/26/2015 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	14E572	B. WING		R 01/22/2015
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COI	DE
SKOKIE MEADOWS NURSING CE			4600 WEST GOLF ROAD	
			SKOKIE, IL 60076	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
to provide any docum 1/21/2015, the care p updates regarding th of R5. R6 is a 68 year old m trauma and Bipolar. R6 had a care plan dat that R6 is cognitively (evidenced by) poor himself, problems wit transmission of inform rarely socializes with communication skills The facility's One-to- purpose as: to provin resident with specific not appropriate for g medical, behavioral a withdrawal, mood sta His documented 1:1 on 12/26/14; 1/9/15; Care plan interventio program of activities resident's abilities lik parties and social ev (bingo/pokeno) that F provoking and requir number and apply th correct application in R6 was observed in a 1/20/2015 sitting alor eyes closed while bir called out. When E	ce. The facility was unable nentation at this time. As of olan does not reflect any e ongoing continence issues han diagnosed with head dated 10/14/2014 and a ted 1/13/2015 that both state impaired; problem is e/b memory, difficulty expressing th reception and mation. Both plans state he others d/t (due to) poor One Protocol states the de a personalized forum for e psychosocial need who a roup intervention due to and/or extreme psychosocial ate-related problems. interventions only occurred 1/16/15 and 1/21/15 ons include: Provide a that accommodates the e non-insight activity groups, ents. Activities R6 attends are thought e the ability to hear a card or e direction by making the a very short period of time.	{F 28		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		PLETED
		14E572	B. WING	 		R 22/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 282} {F 332} SS=D	R6. Witnessed by E- the bingo process is w R6 would best benefit The facility Plan of Co states care plans will revised and updated activity director, care supervisor quarterly/ revised based on thei goals will be validated interventions will be re effectivity. This did not occur for 483.25(m)(1) FREE C RATES OF 5% OR M	6 without any involvement of 13 (PRSC) who agreed that very fast paced and stated t by having 1:1's. prection dated 12/10/2014 be continuously reviewed, by each PRSC/PRSD, plan coordinator and dietary annually. Problems will be ir current issues/problems, d if met/unmet and evised/changed based on R5 or R6. DF MEDICATION ERROR IORE	{F 2 {F 3			
	by: Based on observatio review, the facility fail (5%) or lower medica medication errors out opportunities, resultin error rate. 2 residents supplemental sample Findings include: On 1/20/15 at 11:56a Nurse) administering	g in a 7.4 % medication (R13,R14) from the				

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	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DA	10. 0938-039 TE SURVEY MPLETED
			A. BUILDING			R
		14E572	B. WING			1/22/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
SKOKIE I	IEADOWS NURSING CE	NTERII		1600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
{F 332}	sub-cutanous per flex Observed E9 pointed downward orientation sharps container, the button on the pen to e did not use a tapping bubbles to the needle a result, R13 did not to insulin. On 1/21/15 at 11:55a Nurse), administering medications included sub-cutanous per flex Observed E10 pointe E10 did not " tap the pushed the injection to As a result, R14 did not of insulin. A review of the manu Patient Instruction to FlexPen, under the h- before each injection, injection small amour cartridge during norm and to ensure proper selector to select 2 un NovoLog FlexPen with Tap the cartridge gen time to make any air the cartridge []. G. upwards, press the p].	 a pen administration. a the insulin flex pen in a a into the opening of the n pressed the injection expel the 2 units. Also, E9 motion to move possible air e opening of the flex pen. As receive the correct dose of m, observed E10(Registered g medications to R14. R14's Insulin, Novalog 2 units a pen administration. d the flex pen straight up. flex pen gently, " but rather button to expel the 2 units. not receive the correct dose facturer guideline titled the Use of NovoLog eading " Giving the airshot so f air may collect in the nal use. To avoid injecting air dosing: E. Turn the dose nits []. F. Hold you th the needle pointing up. tly with your finger a few bubbles collect at the top of Keep the needle pointing ush-button all the way in [{F 332}			

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STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	O. 0938-039
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		14E572	B. WING		0,	R I/ 22/2015
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 332}	1 0	e 12 Ianufacturer ' s Instructions.	{F 332]	}		
{F 333} SS=D	On 1/22/15 at 10:15a Nurses who were in-s pen for a return demo 483.25(m)(2) RESID	im, E2 stated ," I did not ask serviced in the use of the flex onstration at that time." ENTS FREE OF	{F 333]	}		
	The facility must ensi any significant medic	ure that residents are free of ation errors.				
	by: Based on observation review, the facility fait are free from signification	is not met as evidenced in, interview and record led to ensure that residents ant medication errors for 2 in the supplemental sample, nt medication errors.				
	On 1/20/15 at 11:56a Nurse) administering medications included sub-cutanous per flex Observed E9 pointed downward orientation sharps container, the button on the pen to did not use a tapping bubbles to the needle	m, observed E9(Registered medications to R13. R13's Insulin, Novalog 2 units of pen administration. If the insulin flex pen in a into the opening of the n pressed the injection expel the 2 units. Also, E9 motion to move possible air e opening of the flex pen. As receive the correct dose of				
		m, observed E10(Registered 9 medications to R14. R14's				

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 01/26/2018 RM APPROVEE IO. 0938-0391		
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		14E572	B. WING		0,	R 1/ 22/2015		
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	EADOWS NURSING CE							
				SKOKIE, IL 60076				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
{F 333}	Continued From page	e 13	{F 333	3}				
	medications included sub-cutanous per flex Observed E10 pointe E10 did not " tap the pushed the injection	Insulin, Novalog 2 units						
	Patient Instruction to FlexPen, under the h before each injection injection small amoun cartridge during norm and to ensure proper selector to select 2 u NovoLog FlexPen wit Tap the cartridge gen time to make any air the cartridge []. G.	A review of the manufacturer guideline titled Patient Instruction to the Use of NovoLog FlexPen, under the heading " Giving the airshot before each injection, " shows " Before each njection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units []. F. Hold you NovoLog FlexPen with the needle pointing up. Fap the cartridge gently with your finger a few ime to make any air bubbles collect at the top of he cartridge []. G. Keep the needle pointing upwards, press the push-button all the way in [].						
	stated," I gave in-ser device to Registered described the use of	n, E2 (Director of Nursing), vice on use of flex pen Nurses in the facility." E2 the flex pen including all the lanufacturer 's Instructions.						
	Nurses who were in-	im, E2 stated ," I did not ask serviced in the use of the flex onstration at that time."						
(F 00 1)	Diabetes. R13 and R includes Diabetes.	at symptoms associated with 14's medical diagnosis						
{F 364} SS=F	483.35(d)(1)-(2) NUT PALATABLE/PREFE	'RITIVE VALUE/APPEAR, R TEMP	{F 364	}				

Facility ID: IL6008643

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		14E572	B. WING				R / 22/2015
NAME OF P	ROVIDER OR SUPPLIER		•	;	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4600 WEST GOLF ROAD			
SKOKIEN	IEADOWS NURSING CE	NIERII		:	SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
{F 364}	Continued From page	e 14	{F 3	364]	}		
	food prepared by met	es and the facility provides thods that conserve nutritive bearance; and food that is and at the proper					
	by: Based on observatio review, the facility fail staff on new policies/ ensure the kitchen sta for recording time and foods and procedure foods from the cookin kitchen, to demonstra calibrate thermomete temperatures, and to holding of cooked foo potential to affect all & Findings include: Per the Plan of Corre date of January 6, 20 written time and temp temperature log for w						
	the receiving kitchen. Staff in both the cook kitchen has been in-s and logs. " Per inse 12/30/15, E6(Dietary E20(Cook) were not i on new policies and p unable to provide doo the cooking	Per the plan of correction " ing kitchen and the receiving erviced on the new policy ervice attendance logs dated Aide), E7(Dietary Aide), and n attendance of inservices procedures. Facility was cumentation showing staff in ed on new policy and logs.					

Facility ID: IL6008643

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	10. 0938-039 TE SURVEY MPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			R	
		14E572	B. WING		0	1/22/2015	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
SKOKIE N	IEADOWS NURSING CE	NTERII		00 WEST GOLF ROAD KOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
{F 364}	On 1/21/2015 at 11:3 confirmed as of 1/20/ well as staff in the co- inserviced on the new per the Plan of Corre- Per the March, 2014 Prepared Foods from 1) when picking up ho will be taken to ensur base temperature of the destination kitche temperature taken to occurred during the tr Temperature Monitori inservice date Dec 30 food temperatures 15 out of a total of 59 me Up/Return/Serving Te for 41 meals were ind total of 59 meals serv Per the Procedure for Temperature of Cook record cooked tempe cooking on the appro in the proper location removed from the over temperature of the for	0AM, E5(Dietary Manager) 2015 E6, E7 and E20, as oking kitchen, were not y policies and procedures as ction. Procedure for Transferring Kitchen to Kitchen states " of foods their temperature e they are at or above the 140F. 6) When arriving at n hot foods will have their ensure no heat loss ransfer. " Per the Food ng Daily Checklist, since the 0, 2015 - January 20, 2015, e entire meals were missing eals served. Per the Pick emp form, food temperatures completely recorded out of a red.	{F 364}				
	Temperature ", as we beginning 1/6/15, has to record the final coor as per the Procedure Temperature of Cook dated 1/1/15-1/19/15,	tems " and " Holding ell as the revised form been utilized until 1/20/15 oking temperatures of foods for Recording Time and ed Foods. Per the forms food temperatures and ere incompletely recorded eals.					

Facility ID: IL6008643

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/26/2015 APPROVED . 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		14E572	B. WING _			R 01/22/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	, STATE, ZIP CODE			
	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROA SKOKIE, IL 60076	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDE (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 364}	by taking temperature kitchen and the receiv week for four weeks is stated the missing da training issue - we are In 1/20/15 at 11:00AN calibrate a thermome temperatures of food I don ' t know how to E5 provided the 2010 Thermometers of the calibrated at regul they calibrate thermo thermometers to the notices the temperature oschedule for calibrate (dietitian) stated the colores and it leaves it On 1/20/2015 at 2:00 dinner were being he 9 minutes left of cook chicken patties were to be heated to 160F approximately 9 minu- patties only needed a minutes to reach 165 that needed to be coor before dinner were F chicken patties were would then place the dinner at 4:45 PM for approximately 2 hour 1/22/2015 at 11:30 A	by reviewing the log daily and es at both the cooking ving kitchen three times per to ensure compliance. " E4 ta was a result of a " e always working on it. " A when E5 was asked to ter in order to take items for lunch, E5 stated " calibrate a thermometer. " D policy " Calibrating ch states " Thermometers emperatures will be ar intervals." E5 stated meters by sending the kitchen next door if she ures of foods are " off " but rating thermometers exist D demonstrate how to e her thermometer. Z1 calibration policy is " pretty open to interpretation. " PM chicken patties for ated in the combi oven with ting. E21 (Cook) stated the pre-cooked and only needed which would occur in ites. Per E21, the chicken a total cooking time of 20 F and the only other product oked in the combi oven rench fries. When the heated, the cook stated he m in the oven to be held until	{F 36	54}				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		14E572	B. WING		R 01/22/2015
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
{F 364}	Per the cooking kitch logs, vegetables were PM dinner service at PM on 1/9/15, at 2:00 on 1/11/15, and 2:09 Based on observation review, the facility fai staff on new policies/ ensure the kitchen st for recording time and foods and procedure foods from the cookin kitchen, to demonstra calibrate thermometer temperatures, and to holding of cooked foo potential to affect all Findings include: Per the Plan of Corre date of January 6, 20 written time and temp temperature log for w cooking and a tempe the receiving kitchen. Staff in both the cook kitchen has been in-s and logs. " Per inse 12/30/15, E6(Dietary E20(Cook) were not i on new policies and p unable to provide doo the cooking On 1/21/2015 at 11: confirmed as of 1/20/ well as staff in the co	en time and temperature e finished cooking for 4:45 2:00 PM on 1/6/15, at 2:00 D PM on 1/10/15, at 2:00 PM PM on 1/13/15. n, interview and record led to inservice all kitchen procedures and logs, to aff followed the procedures d temperature of cooked for transferring prepared ng kitchen to receiving ate ability to correctly	{F 36		

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/26/20 FORM APPROVI OMB NO. 0938-03	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		14E572	B. WING		R 01/22/2015	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C	DN SHOULD BE COMPLETIO IE APPROPRIATE DATE	
{F 364}	Prepared Foods from 1) when picking up he will be taken to ensur base temperature of the destination kitcher temperature taken to occurred during the tr Temperature Monitor inservice date Dec 30 food temperatures 15 out of a total of 59 me Up/Return/Serving Te for 41 meals were inc total of 59 meals serv Per the Procedure for Temperature of Cook record cooked temper cooking on the approvin in the proper location removed from the ow temperature of the for interview with E4 (For form stating "Food If Temperature ", as we beginning 1/6/15, has to record the final coord as per the Procedure Temperature of Cook dated 1/1/15-1/19/15 times for 28 meals we out of a total of 57 me Per the Plan of Correct date of January 6, 20 monitor compliance to by taking temperature	ction. Procedure for Transferring Kitchen to Kitchen states " of foods their temperature re they are at or above the 140F. 6) When arriving at in hot foods will have their ensure no heat loss ransfer. " Per the Food ing Daily Checklist, since the 0, 2015 - January 20, 2015, 6 entire meals were missing eals served. Per the Pick emp form, food temperatures completely recorded out of a red. r Recording Time and ed Foods, " Cooks will ratures and the time finished priate log and sign, or initial, . Record the time foods are en or stove top. Record the ods at this time " Per od Service Director), the tems " and " Holding ell as the revised form a been utilized until 1/20/15 oking temperatures of foods for Recording Time and ed Foods. Per the forms , food temperatures and ere incompletely recorded	{F 36			

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		ID HUMAN SERVICES MEDICAID SERVICES					NTED: 01/26/2015 FORM APPROVED B NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		14E572	B. WING				R 01/22/2015	
NAME OF P	ROVIDER OR SUPPLIER	·		STF	REET ADDRESS, CITY, STATE, ZIP COL	DE		
				4600 WEST GOLF ROAD				
SKOKIE I	EADOWS NORSING CE	NIEKII		SK	OKIE, IL 60076			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
{F 364}	stated the missing da training issue - we are In 1/20/15 at 11:00AN calibrate a thermome temperatures of food I don ' t know how to E5 provided the 2010 Thermometers ' whice used to check food te calibrated at regul they calibrate thermo thermometers to the I notices the temperatur no schedule for calibr and E5 was unable to successfully calibrate (dietitian) stated the of loose and it leaves it On 1/20/2015 at 2:00 dinner were being he 9 minutes left of cook chicken patties were to be heated to 160F approximately 9 minute patties only needed a minutes to reach 165 that needed to be cool before dinner were Fin chicken patties were would then place ther dinner at 4:45 PM for approximately 2 hour 1/22/2015 at 11:30 All patties were cooked to	ADOWDER OR SUPPLIER EADOWS NURSING CENTER I I SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 stated the missing data was a result of a " training issue - we are always working on it. " In 1/20/15 at 11:00AM when E5 was asked to calibrate a thermometer in order to take temperatures of food items for lunch, E5 stated " I don 't know how to calibrate a thermometer. " E5 provided the 2010 policy " Calibrating Thermometers " which states " Thermometers used to check food temperatures will be calibrated at regular intervals. " E5 stated they calibrate thermometers by sending the thermometers to the kitchen next door if she notices the temperatures of foods are " off " but no schedule for calibrating thermometers exist and E5 was unable to demonstrate how to successfully calibrate her thermometer. Z1 (dietitian) stated the calibration policy is " pretty loose and it leaves it open to interpretation. " On 1/20/2015 at 2:00 PM chicken patties for dinner were being heated in the combi oven with 9 minutes left of cooking. E21 (Cook) stated the chicken patties were pre-cooked and only needed to be heated to 160F which would occur in approximately 9 minutes. Per E21, the chicken patties only needed a total cooking time of 20 minutes to reach 165F and the only other product that needed to be cooked in the combi oven before dinner were French fries. When the chicken patties were heated, the cook stated he would then place them in the oven to be held until dinner at 4:45 PM for a total hold time of approximately 2 hours and 35 minutes. On 1/22/2015 at 11:30 AM, Z1 stated that the chicken patties were cooked too early for dinner service. Per the cooking kitchen time and temperature		364}				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/26/2015 1 APPROVED). 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DNSTRUCTION		(X3) DATE SURVEY COMPLETED		
		14E572	B. WING _			R 01/22/2015			
NAME OF PI	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE		-		
	EADOWS NURSING CE	NTERII	4600 WEST GOLF ROAD						
		ATEMENT OF DEFICIENCIES		SK	DKIE, IL 60076	DECTION			
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE	
{F 364}	Continued From page 20		{F 36	64}					
	on 1/11/15, and 2:09								
{F 371} SS=F	483.35(i) FOOD PRC STORE/PREPARE/S		{F 3]	71}					
	The facility must -								
	()	n sources approved or ry by Federal, State or local							
	authorities; and	ry by rederal, State of local							
	(2) Store, prepare, dis under sanitary condit	stribute and serve food							
	by: Based on observatio review, the facility fail staff on new policies/ ensure the kitchen sta for recording time and foods and procedure foods from the cookin kitchen, to demonstra calibrate thermomete temperatures, and pro- handling practices. T potential to affect all a Findings Include:	rs to take food actice safe and sanitary food hese failures have the 82 residents in the facility.							
	date of January 6, 20 written time and temp temperature log for w cooking, and a tempe the receiving kitchen.	ction with the correction 15, the facility initiated a new berature policy, new time and then foods are finished erature log when foods are at Per the plan of correction " ing kitchen and the receiving							

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 01/26/2019 APPROVED). 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTF		(X3) DATE SURVEY COMPLETED R 01/22/2015		
		14E572	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET A	DDRESS, CITY, STATE, ZIP CO	DDE		
	EADOWS NURSING CE		4600 WEST GOLF ROAD					
				SKOKIE,	, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE		(X5) COMPLETION DATE
{F 371}	371} Continued From page 21 kitchen has been in-serviced on the new policy and logs. " Per inservice attendance logs dated 12/30/15, E6(Dietary Aide), E7(Dietary Aide), and E20(Cook) were not in attendance of inservices on new policies and procedures. Facility was unable to provide documentation showing all staff in the cooking kitchen was inserviced on new policy and logs. On 1/21/2015 at 11:30AM, E5		{F 37	/1}				
	(Dietary Manager) co E7 and E20, as well a cooking kitchen, were policies and procedur Correction. Per the March, 2014	721/2015 at 11:30AM, E5 nfirmed as of 1/20/2015 E6, as dietary aide staff in the e not inserviced on the new res as per the Plan of Procedure for Transferring Kitchen to Kitchen states "						
	1) when picking up he will be taken to ensur base temperature of the destination kitche temperature taken to occurred during the taken	ot foods their temperature re they are at or above the 140F. 6) When arriving at in hot foods will have their ensure no heat loss ransfer. " Per the Food						
	inservice date Dec 30 food temperatures 15 out of a total of 59 me Up/Return/Serving Te	ing Daily Checklist, since the 0, 2015 - January 20, 2015, 5 entire meals were missing eals served. Per the Pick emp form, food temperatures completely recorded out of a						
	total of 59 meals serv Per the Procedure for Temperature of Cook record cooked temper	red. r Recording Time and ed Foods, " Cooks will ratures and the time finished						
	in the proper location removed from the over temperature of the fo	priate log and sign, or initial, . Record the time foods are en or stove top. Record the ods at this time "Per od Service Director), the						
	form stating "Food I Temperature ", as we	tems " and " Holding ell as the revised form s been utilized until 1/20/15						

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		IO. 0938-039 E SURVEY	
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:			CON	IPLETED	
					R		
		14E572	B. WING		0	1/22/2015	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		E		
SKOKIE M	IEADOWS NURSING CE	NTERII		500 WEST GOLF ROAD KOKIE, IL 60076			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	PECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETIO DATE	
{F 371}	Continued From page	e 22	{F 371}				
	1.0	oking temperatures of foods	(,				
		for Recording Time and					
		ed Foods. Per the forms					
	dated 1/1/15-1/19/15	, food temperatures and					
		ere incompletely recorded					
	out of a total of 57 m						
		ection with the correction					
		15, "Dietary Manager will					
		by reviewing the log daily and					
		es at both the cooking ving kitchen three times per					
		to ensure compliance. " E4					
		ata was a result of a "					
	-	e always working on it. "					
	-	M when E5 was asked to					
	calibrate a thermome	eter in order to take					
	•	items for lunch, E5 stated "					
		calibrate a thermometer. "					
	E5 provided the 2010						
		ch states "Thermometers					
	used to check food to	•					
		lar intervals. " E5 stated meters by sending the					
		kitchen next door if she					
		ures of foods are " off " but					
		rating thermometers exist					
		o demonstrate how to					
	successfully calibrate	e her thermometer. Z1					
		calibration policy is " pretty					
		open to interpretation. "					
		E6 was preparing tuna					
		away from his food prep					
		neter while leaving the tuna					
	-	the food prep area with the ands, and proceeded to					
		tuna without changing his					
		s hands. On 1/20/15 at					
	giordo or waariing his		1			1	
	12:00 PM, E6 touche	d his face with gloved hands					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		14E572	B. WING				R / 22/2015
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SKOKIE N	IEADOWS NURSING CEI	NTERII			4600 WEST GOLF ROAD SKOKIE, IL 60076		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION DATE
{F 371}	hands. Review of facilities for policy indicates that s immediately after han their clothing, skin, ha On 1/20/15 at 12:15P dated 1/14/15 for coo began at 9:10AM at 1 product at 10:10AM at shows product at 11:1 12:10AM at 65F. Per	e 23 ch without washing his od service handwashing taff are to wash hands ids coming in contact with air, jewelry or equipment. 'M, review of the cooling logs ked pork indicated cooling 71F. The next data shows it 120F. The next data 10AM at 89F, and then the data collected, unable ooled from 135F to 70F	{F 3	371}	DEFICIENCY)		
	review, the facility fail staff on new policies/j ensure the kitchen sta for recording time and foods and procedure foods from the cookin kitchen, to demonstra calibrate thermometer temperatures, and pra handling practices. T potential to affect all & Findings Include: Per the Plan of Corre- date of January 6, 20 written time and temp	te ability to correctly					

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					OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,		(X3) DATE SURVEY COMPLETED			
	14E572		A. BUILDING			R	
			B. WING		01/22/2015		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP					
				4600 WEST GOLF ROAD			
SKOKIE N	IEADOWS NURSING CE	NTERII		SKOKIE, IL 60076			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPI DEFICIENCY)		OULD BE COMPLETIC		
{F 371}	Continued From page	24	{F 371	n			
1 2/15	Continued From page 24 cooking, and a temperature log when foods are at the receiving kitchen. Per the plan of correction " Staff in both the cooking kitchen and the receiving kitchen has been in-serviced on the new policy		{ - 3/	1}			
	and logs. " Per inservice attendance logs dated						
	12/30/15, E6(Dietary Aide), E7(Dietary Aide), and						
	E20(Cook) were not i	n attendance of inservices					
		procedures. Facility was					
		unable to provide documentation showing all staff					
	in the cooking kitchen was inserviced on new						
	policy and logs. On 1/21/2015 at 11:30AM, E5						
	(Dietary Manager) confirmed as of 1/20/2015 E6, E7 and E20, as well as dietary aide staff in the						
		e not inserviced on the new					
	-	res as per the Plan of					
	Correction.						
		Procedure for Transferring					
		Kitchen to Kitchen states "					
		ot foods their temperature					
		e they are at or above the					
		140F. 6) When arriving at					
	the destination kitchen hot foods will have their temperature taken to ensure no heat loss						
		ransfer. " Per the Food					
		ing Daily Checklist, since the					
), 2015 - January 20, 2015,					
		entire meals were missing					
		eals served. Per the Pick					
		completely recorded out of a					
	total of 59 meals serv						
		r Recording Time and					
		ed Foods, " Cooks will					
		ratures and the time finished					
		priate log and sign, or initial,					
		. Record the time foods are					
		en or stove top. Record the					
		ods at this time " Per					
	interview with E4 (Fo	ad Camulaa Dinaatan) tha	1	1		1	

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL		TE SURVEY		
			A. BUILDING				
14E572				R			
		B. WING			01/22/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
SKOKIE N	IEADOWS NURSING CE	NTERII		4600 WEST GOLF ROAD SKOKIE, IL 60076			
				<i>,</i>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	RRECTION I SHOULD BE APPROPRIATE	OULD BE COMPLETION		
{F 371}	Continued From page	- 25	(F 274)				
1 2/17	1 0		{F 371}				
		tems and "Holding					
	Temperature ", as well as the revised form beginning 1/6/15, has been utilized until 1/20/15 to record the final cooking temperatures of foods as per the Procedure for Recording Time and Temperature of Cooked Foods. Per the forms dated 1/1/15-1/19/15, food temperatures and						
		•					
		ere incompletely recorded					
	out of a total of 57 me						
	Per the Plan of Correction with the correction date of January 6, 2015, "Dietary Manager will						
	-						
	-	by reviewing the log daily and					
		es at both the cooking ving kitchen three times per					
		to ensure compliance. " E4					
		ita was a result of a "					
		e always working on it. "					
	-	M when E5 was asked to					
	calibrate a thermome						
		items for lunch, E5 stated "					
		calibrate a thermometer. "					
	E5 provided the 2010						
		ch states "Thermometers					
	used to check food te						
		ar intervals. " E5 stated					
		meters by sending the					
		kitchen next door if she					
		ures of foods are " off " but					
		rating thermometers exist					
		o demonstrate how to					
		her thermometer. Z1					
		calibration policy is " pretty					
		open to interpretation. "					
		E6 was preparing tuna					
		away from his food prep					
		neter while leaving the tuna					
		the food prep area with the					
	-	ands, and proceeded to					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								PRINTED: 01/26/2015 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
14		14E572	B. WING		_	R 01/22/2015			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE						
SKOKIE MEADOWS NURSING CENTER I I			4600 WEST GOLF ROAD SKOKIE, IL 60076						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 371}	12:00 PM, E6 toucher and immediately touc was preparing for lunc hands. Review of facilities for policy indicates that s immediately after han their clothing, skin, ha On 1/20/15 at 12:15P dated 1/14/15 for coo began at 9:10AM at 1 product at 10:10AM at shows product at 11:7 12:10AM at 65F. Per	e 26 a hands. On 1/20/15 at d his face with gloved hands hed ham sandwiches he ch without washing his od service handwashing taff are to wash hands ids coming in contact with air, jewelry or equipment. M, review of the cooling logs ked pork indicated cooling 71F. The next data shows at 120F. The next data 10AM at 89F, and then the data collected, unable cooled from 135F to 70F	{F :	371}					

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