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

PRINTED: 08/15/2006 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	
		IDENTIFICATION NOMBER.					
		145661	B. WING			04/20/2006	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
JACKSON SQUARE N & REHAB CTR					130 WEST JACKSON BOULEVARD HICAGO, IL 60644		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	ON SHOULD BE CROSS-	
F 411	Continued From page 16		F 41				
	dental care is need resident and /or res	y dated 10/03 stated," (2). If ed, the nurse informs the sponsible party. (7). Nursing al issues in the nursing notes e.					
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION		F99	999			
	300.1210b)6)						
	Section 300.1210 General Requirements for Nursing and Personal Care b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. This regulation is not met, as evidenced by the following:						
	facility failed to ensor	ion, and staff interview, the ure the environmental safety eaving a hazardous work area rs) unsecured with barriers or 17/06.					
	Findings include:						
	the surveyor went of the 1st floor. Surve doors wide open re elevator shaft. An e working on the roof	to use the south elevator on eyor observed the elevator vealing an open area in the elevator employee was for the elevator cab. The opproximately 4'-5' below the					

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F9999	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F99	999			