CENTERS FOR MEDICARE	& MEDICAID SERVICES				CIMB M	<u>0. 0938-0391</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
145434		B. Wil	NG		C 07/20/2007		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL				
CLARIDGE HEALTHCARE CE	NTER		l	KE BLUFF, IL 60044			
PREFIX (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 APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
the hot weather p	ays Iff about implementation of blan. ature logs for each floor.		999				
a) The facility shall procedures, govern the facility which shall resident Care Policile least the administrative medical advisor representatives of mother facility. These point with the Act and all These written policile operating the facility least annually by this written, signed and meeting. Section 300.1210 Government of the facility must and services to attate practicable physical well-being of the research resident's complan of care. Adequiver.	esident Care Policies have written policies and ing all services provided by all be formulated by a cy Committee consisting of at itor, the advisory physician or y committee and nursing and other services in olicies shall be in compliance rules promulgated thereunder. es shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/15/2007

FORM APPROVED

		& MEDICAID SERVICES						M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[AULTIPL	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
145434			B. WI	NG			C 07/20/2007	
NAME OF F	PROVIDER OR SUPPLIER			Į.	ET ADDRESS, CITY, STATE,	ZIP CODE		
CLARID	GE HEALTHCARE CE	NTER			JENKISSON KE BLUFF, IL 60044			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX :	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHO	OULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 10	F9	999				
	•	ls of the resident. Restorative lude at a minimum the es:		!				
	e) Heating, Cooling 1) A design temper Fahrenheit for both conditions shall be areas including cor 6) Air conditioning a be designed, install	Mechanical Systems I, and Ventilating Systems ature of 75 degrees summer and winter design provided for all resident use ridors. and ventilation systems shall led and maintained as required official of the standard						
	These Requirements are not met as evidenced by:							
	interviews, and poli provide comfortable facility and failed to	ions, staff and resident cy review, the facility failed to e temperatures within the take action to reduce resident ing, or following its Hot						
	and output. 2) Failed to have fravailable to all residents for significant or an arms.							
	 Failed to docum temperatures ar 							

PRINTED: 10/15/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 B. WING 145434 07/20/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 JENKISSON CLARIDGE HEALTHCARE CENTER LAKE BLUFF, IL 60044 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F9999 Continued From page 11 F9999 This was observed on three floors of the facility. Findings include: On 07/09/2007, when the surveyors entered the building, facility staff made the surveyors aware that the air conditioning system had broken down. E1 told the surveyor that a contractor had been called, and would be at the facility as soon as possible. At 11:00AM the following conditions were noted on the first floor of the building: Room Temp. Relative Heat Humidity Index Nurses 92F 56% 98 Station Dining 88F 58% 98 Room 88F 56% 98 Hall #109 85F 66% 91 A heat index between 90 to 104 can result in heat cramps and heat exhaustion. Both are possible with prolonged exposure and/or physical activity. At approximately 1:15PM, a contractor arrived at the facility and began to repair the A/C system. Surveyor asked the facility for a copy of its hot

called for staff to:

symptoms.

weather policy. The facility's Hot Weather plan

Monitor residents for fluid intake and output

Monitor residents for signs and symptoms of discomfort and adverse physical

Identify and monitor high risk residents.

Check residents' temperatures and vital signs

and to encourage Fluids.

DEPAR'	TMENT OF HEALTH	I AND HUMAN SERVICES					APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145434	B. WIN	IG		07/2	C 20/2007
NAME OF P	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	=	
CLARIDO	GE HEALTHCARE CE	NTER			JENKISSON KE BLUFF, IL 60044		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 12	F99	999			
	at least every 4-	6 hours.					1
		to cooler areas in the facility.		; !	•		
	After review the su	rveyors went to to observe the					
		s to see if the hot weather plan					
	had been implemer						
		veyor asked E4 (Charge					
	Nurse, 3rd floor) to identify the rooms housing individuals that were at risk, due to the extreme			j			
		building. The temperature and					
		the nurses' station at that time					
	were 75 and 67% re	espectively.					
		ne conditions in the rooms					
	identified by E4:			į			}
	Room 305 - Temp 8						
	Room 306 - Temp 8	Pitcher warm to the touch.					
		4 full, temperature 84F					
	Room 307 - Temp 8						
		water in Pitcher was 80 F					
	Room 324 - Temp 8						
	Room 328 - Temp 8						
		Pitcher warm to the touch					1
		84F; Humidity 56%;					
,		Pitcher warm to the touch 84F; Humidity 56%;					
	No water availab						
		is observed, and no water was					}
	available at the nurs						
	Room 307 R12 con	nplained of the heat in her					
ļ		here was no fresh water in her					
İ	pitcher.						
!	At 2:40PM, surveyo	or interviewed E5 and E6, the					
į		the second floor. They were					[
		ny residents at risk due to the		į			
	hot weather.			:			ţ
	The following are th	e conditions in the rooms					!

PRINTED: 10/15/2007

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

PRINTED: 10/15/2007 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLANC	DEPTH OF CONNECTION		A. BUIL	DING			
		145434	B. WING			C 07/20/2007	
NAME OF PROVIDER OR SUPPLIER CLARIDGE HEALTHCARE CENTER				STREET ADDRESS, CITY, STA 700 JENKISSON LAKE BLUFF, IL 60044			
	SI IMMARY STA	TEMENT OF DEFICIENCIES	ID			ION	
(X4) ID PREFIX TAG			PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F9999	randomly selected N. Dining Room - Room 202 - Temp No water available Room 203 - Temp No water available Room 206 - No water available Room 207 - Temp No water available Room 208 - Temp No water available Room 203 - Temp No water available Room 233 - No water Room 234 - No water Room 234 - No water station. In an intervanonymity stated the provided with water because they have Dementia. At 3:00PM, E7 identification floor that were at rist The following are the randomly selected because they have Dementia. At 3:00PM, E7 identification floor that were at rist The following are the randomly selected because they have Dementia. At 3:00PM, E7 identification floor that were at rist The following are the randomly selected because they have Dementia.	oy the surveyor Temp 81F; Humidity 65%; 30F; Humidity 65%; ble in room 30F; Humidity 65%; ble in room 30F; Humidity 66%; ble in room 30F; Humidity 68%; ble in room and	F99				
:							:

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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 10/15/2007 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING	•	COMPL	COMPLETED	
145434			B. WII	1G		C 07/20/2007		
NAME OF PROVIDER OR SUPPLIER CLARIDGE HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 JENKISSON LAKE BLUFF, IL 60044					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
F9999	The facility's hot we preventative mainte cooling system. Do indicates that there system since 6/2/07	ge 14 ather plan fails to address any nance for the buildings cumentation provided have been problems with the with onsite visits from the n 6/2, 6/7, 7/7, 7/9 & 7/12. (A)	F99	999	DEFICIENCY)			
	7(02-99) Previous Versions C	theolete Event ID: EM4211			ID: II 6005444			

(X2) MULTIPLE CONSTRUCTION