

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

PRINTED: 01/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2008
NAME OF PROVIDER OR SUPPLIER WOODSTOCK RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 309 MCHENRY AVENUE WOODSTOCK, IL 60098		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 281 SS=D	<p>Complaint Investigation 0875422/IL38650-No Deficiency 0875476/IL38709-F281</p> <p>No extended survey conducted. 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Record Review, Interview and Observation the facility failed to follow physicians orders to notify him with high blood glucose levels. This is for one of three residents sampled. (R1)</p> <p>Findings include;</p> <p>The record of R2, an 81 year old female admitted to the facility with diagnoses including Diabetes was reviewed. R2's record contains a physicians order that states "...blood glucose over 400 give 18 units of Novolog 100 and call MD..." R2's record contains blood glucose monitoring documentation on 11/15/08 at 11 AM that states her blood glucose was 409 and the physician was not notified. R2's record contains documentation on 11/28/08 that her blood glucose was 459 and the physician was not notified. R2's record contains documentation that on 11/20/08 and 11/23/08 at 4 PM on both dates, her blood glucose was 458 and 468 respectively and the physician was not notified.</p>	F 281			
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.

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

PRINTED: 01/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/17/2008
NAME OF PROVIDER OR SUPPLIER WOODSTOCK RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 309 MCHENRY AVENUE WOODSTOCK, IL 60098		
(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 1 In an interview with E2, the director of nursing, she stated that the physicians should have been called for the high blood glucose levels of R1 as ordered by the physician. R2 was observed lunch and ate 75 percent of her meal. R2 states she like the facility and has no complaints.	F 281			