

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

PRINTED: 06/19/2008
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 06/03/2008
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 253 SS=E	<p>Complaint Investigations 0872530/IL35459 =no deficiency 0872271/IL35165 = F253</p> <p>No extended survey was conducted.</p> <p>483.15(h)(2) HOUSEKEEPING/MAINTENANCE</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to maintain a comfortable environment for the residents who are non-smokers. Example :</p> <p>There is not proper ventilation in the smoking room, the fan does not work to adequately prevent smoke from entering the dining room other areas in the building that causes discomfort to nonsmokers. Interviews were conducted with R16 who stated to surveyor that this causes him to be congested since his admission to this facility. R56 also stated that the smoke gives him a severe headache. R57 and R58 also complained that the smoke also causes them discomfort.</p> <p>On 6-30-08 after the smoking room was again reopened, residents continued to complain about the smoke in the dining room coming out of the smoking room. Per observation, the smoking room wall exhaust was not working and dusty. The ceiling fan was on and was blowing out</p>	F 253			
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.

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F 253	Continued From page 1 smoke to the dining room every time the door was opened by residents and staff	F 253			