Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						
		IL6005144	B. WING		06/0	6/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CLARIDO	GE HEALTHCARE CE	NTER 700 JENK LAKE BL	UFF, IL 6004	14		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure a	nd Certification				
S9999	Final Observations		S9999			
	300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.1220b)3) Section 300.610 R a) The facility procedures governifacility. The written be formulated by a Committee consistiadministrator, the amedical advisory conformed and othe policies shall comport may be facility and shall by this committee, and dated minutes Section 300.1010 I h) The facility physician of any acchange in a resider health, safety or we but not limited to, the manifest decubitus	divisory physician or the ommittee, and representatives or services in the facility. The ly with the Act and this Part. It is shall be followed in operating I be reviewed at least annually documented by written, signed				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/01/24 **Electronically Signed**

STATE FORM 6899 If continuation sheet 1 of 16 C6HN11

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
	IL6005144	B. WING		06/06/2024	
NAME OF PROVIDER OR SUPPLIE	FNTER 700 JEN		STATE, ZIP CODE	·	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
of notification. Section 300.1210 Nursing and Pers b) The facilicare and services practicable physically well-being of the each resident's coplan. Adequate a care and persons resident to meet care needs of the d) Pursuant nursing care sha following and sha seven-day-a-weet 3) Objective resident's conditicational change determining care further medical emade by nursing resident's medical emade by nursing resident's medical emade by nursing resident's medical section 300.1220 Services b) The DON nursing services 3) Developinglan for each rescomprehensive as	General Requirements for onal Care y shall provide the necessary to attain or maintain the highest cal, mental, and psychological resident, in accordance with comprehensive resident care and properly supervised nursing all care shall be provided to each the total nursing and personal resident. to subsection (a), general include, at a minimum, the ll be practiced on a 24-hour, k basis: observations of changes in a con, including mental and required and the need for valuation and treatment shall be staff and recorded in the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. DUILDING:			
		IL6005144	B. WING		06/	06/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLARID	GE HEALTHCARE CE	NTER 700 JENR LAKE BL	(ISSON UFF, IL 6004	14		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
S9999	Personnel, represe nursing, activities, or modalities as are or be involved in the plan. The plan shareviewed and modineeded as indicated. The plan shall be remonths. These Regulations Based on interview failed to ensure the immediately notified for a resident receive failure resulted in a being assessed by interventions to prefacility failed to ensure the immediately notified for a resident receive failure resulted in a being assessed by interventions to prefacility failed to ensure the completed for a resident resulted in a being assessed by interventions to prefacility failed to ensure the completed for a resident resulted in a being assessed by interventions to prefacility failed to ensure the completed for a resident residen	nting other services such as dietary, and such other redered by the physician, shall preparation of the resident care II be in writing and shall be fied in keeping with the care do by the resident's condition. Eviewed at least every three are not met as evidenced by: and record review the facility Registered Dietician was do for a significant weight loss wing enteral feedings. This delay in a resident (R24) the dietician to implement vent further weight loss. The ure weekly weights were sident (R1) on enteral feedings of reviewed for enteral feedings	S9999			
	The findings include	e:				
	enteral feedings thr tube). Hospital reco hospital show he w	e plan shows he requires rough a Gastrostomy tube (Gords from a local community as hospitalized from 2/28/24 placement of a gastrostomy				
	(Registered Dieticia was re-admitted fro feeding orders for a Glucerna 1.2 at 60	sessment completed by V7 an/RD) on 3/25/24 show he om the hospital with tube a continuous tube feeding of (ml) milliliters per hour. These ed by V7, at the request of the				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6005144	B. WING		06/06/2024	
	PROVIDER OR SUPPLIER	NTER 700 JENK		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	facility, to bolus feed R24's weight summy weight was 101.0 lb weight was 91 pour in 4 days. On 4/15/from 91 lbs. to 87.8 days. R1's nursing that V7(RD) or V29 Director) were notificated by the facility 1 days and to chart that in V2 stated she was significant was 100 lbs.	dings QID (four times a day). nary shows on 4/1/24, R24's bs. (pounds). On 4/4/24 R24's hds, a 10 lb., 9.9% weight loss 24, R24's weight had dropped 8 lbs, another 3.2 lbs in 11 progress notes do not show (R24's Physician and Medical fied of R24's significant weight note completed by V7 (RD) on htient with significant weight 1 month, Discussed with RN htinuous tube feeding to meet htient." A physician's order hys R24's tube feeding was set to a continuous feeding of	S9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
,	o. oo.u.2011o.u		A. BUILDING:			
		IL6005144	B. WING	B. WING		06/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
CLARID	GE HEALTHCARE CE	NTFR	KISSON LUFF, IL 6004	14		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
S9999	month. On 6/5/24 at 10:35 stated he was notif not sure of the date unaware that the motes in the mailboher to notify her of state they will have the Registered Die immediately. On 6/5/24 at 11:41 Nurse/RN) stated the directly they let V3 know and then put mailbox. V16 states physician who usual Dietician. The facility provide dated 2017 describes in one month, 76 months. The policand dietician should indicate a time framed. R1's Medication he receives enteral Jevity 1.2, 300 ml aml. at dinner. R1's 2/12/24 Nutritishows the resident loss of 8% in 6 months.	AM, V29 (R24's Physician) fied of R24's weight loss but e. V29 stated he was also ursing staff were only leaving ox for V7 (RD) and not calling significant weight loss. V29 e to fix that process because tician should be notified AM, V16 (Registered they do not call the Dietician (Assistant Director of Nursing a note in the Dieticians d they should call the resident ally tells them to notify the ded Weight Monitoring policy pes significant weight loss as 7.5% in 3 months, and 10% in cy shows that the physician d be notified but fails to		DEFICIENCY)		
	weighed 132.0 lbs.	nary report shows on 2/5/24 he but, no further weight is 3/12/24. One month after V7				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6005144	B. WING		06/06/2024	
	PROVIDER OR SUPPLIER GE HEALTHCARE CE	NTFR 700 JENK		STATE, ZIP CODE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	ordered weekly we On 6/4/24 at 10:32 history of refusing to consume his regular ordered the weekly weight and she expression weights when it is on the facility provided dated 2017 describes 5% in one month, 76 months. The policant dietician should indicate a time frant that a client's body maintain acceptables status. Statement of Licent 300.610 at 300.2010a) 300.2010b)	ights for R24. AM, V7 (RD) stated R1 has a she bolus feedings so he can ar diet order. V7 stated she weights to keep track of his pects the facility to do the ordered. d Weight Monitoring policy less significant weight loss as 7.5% in 3 months, and 10% in by shows that the physician doe notified but fails to he. The policy additional shows weight is monitored to be parameters of nutritional (B) sure Violations 2 of 3: desident Care Policies shall have written policies and ing all services provided by the policies and procedures shall Resident Care Policy	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IL6005144	B. WING		06/0	06/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CLARID	GE HEALTHCARE CE	NTER 700 JENK LAKE BLI	ISSON JFF, IL 6004	14		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
\$9999	by this committee, of and dated minutes. Section 300.1210 (Nursing and Person b) The facility scare and services to practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the resident to meet the care needs of t	documented by written, signed of the meeting. General Requirements for hal Care shall provide the necessary of attain or maintain the highest lands, and psychological sident, in accordance with aprehensive resident care la properly supervised nursing care shall be provided to each the total nursing and personal resident. Director of Food Services The responsible for the total revices of the facility. This duty a minimum of 40 hours	S9999			

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	IT OF DEFICIENCIES		(V2) MULTIPL	E CONSTRUCTION	(V2) DATE	QUDVEV
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDING.			
		II 0005444	B. WING		00/0	0/0004
		IL6005144	D. WINO		06/0	6/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CI ARIDO	CLARIDGE HEALTHCARE CENTER 700 JEN					
OLAND	SE TIERETTIORILE SE	LAKE BLU	JFF, IL 6004	14		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
				DEFICIENCY)		
S9999	Continued From pa	ge 7	S9999			
		iipment; and clinical				
	observations of nutrition, nutritional intake,					
	resident's eating habits and preferences, and dietary restrictions.					
	Skilled nursing facilities: A minimum of					
		ulting time per month shall be				
		s with 50 or fewer residents.				
	An additional five minutes of consulting time per month shall be provided per resident over 50 residents, based on the average daily census for the previous year.					
	Section 300.2040 [Diet Orders				
	b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian.					
	2) The diet sha	all be served as ordered.				
	These Regulations	are not met as evidenced by:				
	review, the facility fa were supervised an manager resulting i receiving incorrect presulted in R6 chok maneuver. R6 requaspiration pneumor	on, interview, and record ailed to ensure dietary staff of trained by a qualified dietary n R6, R53, R21, and R65 physician prescribed diets and ing, requiring the Heimlich ired hospitalization for hia and remains at risk for choking and aspiration due to g the incorrect diet.				
		to 4 of 4 residents (R6, R53, ewed for mechanical soft diets				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6005144	B. WING		06/0	6/2024
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	0/2024
CI ARIDO	GE HEALTHCARE CE	700 JENK				
OLAND	Г	LAKE BLU	JFF, IL 6004			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	age 8	S9999			
	The findings includ	e:				
	Manager/FSM) star food service manager only has a food protein that has expired. We manager. V4 has manager. V5 has manager. V6 has manager. V6 has manager. V7 has manager. V6 has manager. V	PM, V4 (Food Service ted he has been in his role as ger for about three years. V4 beection manager certification /4 is not a certified dietary not begun the process of the certified dietary manager /3/24. V4 stated that he w exactly what to do in his t someone on site at all times when he has questions. Protection manager an expiration date of 4/23/24. AM, V7 (Registered that she is contracted to the facility per month which inducting resident nutrition has never attended a neeting with all of the dietary led printed information for the				
	worked here for ab by V4 (FSM) and for a current food prote V9 stated that a me using a knife and c pieces, roughly the pinky finger. V9 do or device to prepar stated chopped me canned fruit, and fr mechanical soft die	AM, V9 (Cook) stated she has out eight years. V9 was trained ormer cooks on the job. V9 has ection manager certification. echanical soft diet is prepared utting the item into bite-size size of the fingernail on a es not use any type of machine e the mechanical soft diet. V9 eats, cooked vegetables, esh fruit are allowed on a et. V9 stated V7 (RD) does not a and V9 has not received.				

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training from V7. Per V9, the most recent

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ILB005144 NAME OF PROVIDER OR SUPPLIER TO JENKISSON LAKE BLUFF, IL. 60044 PROVIDER STREET ADDRESS, CITY, STATE, ZIP CODE TO JENKISSON LAKE BLUFF, IL. 60044 PROVIDERS PLAN OF CORRECTION (EACH OGRECTIVE ACTION SHOULD BE PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES TAG SUMMARY STATEMENT OF DEPICIENCIES TAG SUMMARY STATEMENT OF DEPICIENCIES TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S9999 Continued From page 9 In-service provided by V4 was a few months ago and covered being careful to send the correct foods for each resident. On 6/4/24 at 9.03 AM, V8 (Dietary Aide) stated he reads all of the diet is signified by a green sticker on the diet card. Mechanical soft diet are to receive soft and chopped foods, roughly the size of the fingernal on a pinky finger. V8 stated that residents receiving a mechanical soft diet can receive a lettuce said as long as the contents of the salad, those need to be chopped up as well; they cannot be large places. Facility provided dietary staff certificates indicate that V10 (Dietary Aide), V11 (Dietary Aide) do not have current food handler's certifications. V12's (Cook) Food Protection Manager's certificate has an expiration date of 2/13/24 and is not currently active. R6's progress note dated 4/22/24 shows, "Writer was called to R6's room, resident was choking. 911 was called. Heimlich maneuver was performed, a piece of tomato was expelled." On 6/3/24 at 1:02 PM, V5 (LPN) stated that at the time of the choking event, R6 was lying in bed. V5 was called into R6's room by V6 (Certified	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
CLARIDGE HEALTHCARE CENTER TAG SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION PREFIX PROVIDER ACTION SHOULD BE COMPLETE PROVIDER ACTION SHOULD BE CROSS-REFERENCIA OF COMPLETE PROVIDER ACTION SHOULD BE CROSS-REFERENCIA OF COMPLETE PROVIDER ACTION SHOULD BE CROSS-REFERENCIA OF COMPLETE PROVIDER ACTION SHOULD BE CROSS-REFERENCIA ON PROVIDER ACTION TO PROVIDE ACTION SHOULD BE CROSS-REFERENCIA ON PROVIDER ACTI			IL6005144	B. WING		06/	06/2024
CALARIDGE HEALTHCARE CENTER CAME BLUFF, IL 60044 CALARIDGE CAME DEPICIENCE MUST BE PRICEDED BY FULL RESULTION OF OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CIMPETED TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CIMPETED TAG	NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 9 In-service provided by V4 was a few months ago and covered being careful to send the correct foods for each resident. On 6/4/24 at 9:03 AM, V8 (Dietary Aide) stated he reads all of the diet cards during service and notifies the chef as to what to put on each plate. A mechanical soft diet is signified by a green sticker on the diet card. Mechanical soft diet sare to receive soft and chopped foods, roughly the size of the fingernal on a pinky finger. V8 stated that residents receiving a mechanical soft diet can receive a lettuce salad as long as the contents of the salad are chopped finely, similar in size to the chopped meats. If formatics are a part of the salad, those need to be chopped up as well; they cannot be large pieces. Facility provided dietary staff certificates indicate that V10 (Dietary Aide), V11 (Dietary Aide), V13 (Dietary Aide), and V14 (Dietary Aide) do not have current food handler's certifications. V12's (Cook) Food Protection Manager's certificate has an expiration date of 2/13/24 and is not currently active. R6's progress note dated 4/22/24 shows, "Writer was called to R6's room, resident was choking. 911 was called. Heimlich maneuver was performed, a piece of tomato was expelled." On 6/3/24 at 1:02 PM, V5 (LPN) stated that at the time of the choking event, R6 was lying in bed. V5 was called into R6's room by V6 (Certified	CLARID	GE HEALTHCARE CE	NTFR		14		
in-service provided by V4 was a few months ago and covered being careful to send the correct foods for each resident. On 6/4/24 at 9:03 AM, V8 (Dietary Aide) stated he reads all of the diet cards during service and notifies the chef as to what to put on each plate. A mechanical soft diet is signified by a green sticker on the diet card. Mechanical soft diets are to receive soft and chopped foods, roughly the size of the fingernall on a pinky finger. V8 stated that residents receiving a mechanical soft diet can receive a lettuce salad as long as the contents of the salad are chopped finely, similar in size to the chopped meats. If tomatoes are a part of the salad, those need to be chopped up as well; they cannot be large pieces. Facility provided dietary staff certificates indicate that V10 (Dietary Aide), V11 (Dietary Aide), V13 (Dietary Aide), and V14 (Dietary Aide) do not have current food handler's certifications. V12's (Cook) Food Protection Manager's certificate has an expiration date of 2/13/24 and is not currently active. R6's current diet card shows R6 should receive a mechanical soft diet. R6's progress note dated 4/22/24 shows, "Writer was called to R6's room, resident was choking. 911 was called. Helmlich maneuver was performed, a piece of tomato was expelled." On 6/3/24 at 1:02 PM, V5 (LPN) stated that at the time of the choking event, R6 was lying in bed. V5 was called into R6's room by V6 (Certified	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
Nursing Assistant (CNA)). When V5 entered R6's room, R6 was purple and could not speak. V5	\$9999	in-service provided and covered being foods for each residence on 6/4/24 at 9:03 Areads all of the diet notifies the chef as mechanical soft die on the diet card. Moreceive soft and chof the fingernail on residents receiving receive a lettuce sathe salad are chopped meats. If it salad, those need to cannot be large pied. Facility provided diethat V10 (Dietary Aide), and current food handled V12's (Cook) Food certificate has an enot currently active. R6's current diet camechanical soft diethat V10 (Pietary Aide). The composition of the composition of the composition of the composition of the choking was called into R6's Nursing Assistant (V12's Cook) Food certificate has an enot currently active.	by V4 was a few months ago careful to send the correct dent. AM, V8 (Dietary Aide) stated het cards during service and to what to put on each plate. It is signified by a green sticked echanical soft diets are to apped foods, roughly the size a pinky finger. V8 stated that a mechanical soft diet can alad as long as the contents of ped finely, similar in size to the tomatoes are a part of the to be chopped up as well; they exces. The tart of the total carries are to be chopped up as well; they exces. The tart of the total carries are to appear to the tomatoes are a part of the total carries are a part of the state and a part of the total carries are a part of the state are total carries are a part of the state are total carries are to a part of the state are total carries are total carries are to a part of the state are total carries are to a part of the total carries are total carries are to a part of the total carries are total carries are to a part of the total carries are total	e Arr e s s			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		IL6005144	B. WING		06/0	6/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
CLARID	GE HEALTHCARE CE	NTER 700 JENK LAKE BLI	ISSON JFF, IL 6004	14		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
\$9999	initiated the Heimlick tomato piece, apprograme flying out." We mechanical soft die R6's progress note "Resident readmitte paramedics. He was antibiotics to treat a local hospital On liquid" Facility served mer served for the day is pesto chicken salac cucumber and onion topping, and a dinner served for the day is pesto chicken salac cucumber and onion topping, and a dinner facility diet spreadmechanical soft die tomato rather than On 6/2/24 at the no into cubes, a baked and fresh cantalous On 6/3/24 at the no lasagna, California bread, and apple significant or control of the service of	ch maneuver on R6 and a eximately the size of a quarter, 75 stated R6 was receiving a et on 4/22/24 and is still on a et. dated 4/28/24 shows, ed from local hospital via local is on IV (intravenous) aspirated pneumonia while at minced moist diet with thin on the for 4/22/24 shows the meal includes a tomato wedge, d., potato chips, marinated in salad, pudding with whipped er roll. Sheet for 4/22/24 shows that a et should have received a diced a full tomato wedge. Son meal, R6 received ham cut di potato with the skin, spinach, on meal, R6 received meat blend vegetables, garlic	\$9999			
	on 6/2/24 at the nowhole hot dog on a cantaloupe cut into	on meal, R53 received a bun, spinach, and fresh				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		IL6005144	ı	B. WING		06/	06/06/2024	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CLARID	GE HEALTHCARE CE	NTER	700 JENK LAKE BL	(ISSON UFF, IL 6004	14			
(X4) ID PREFIX TAG		TEMENT OF DEFICI MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
S9999	"absolutely not appress mechanical soft die R21's current diet of (mechanical soft)." On 6/2/24 at the not cut into cubes, a bat and fresh cantaloup. On 6/3/24 at the not lasagna, California bread, and apple slatexture. R65's physician ord R65 is on a general texture. R65's current diet of not exture modification of ham, a baked pofresh cantaloupe. On 6/2/24 at the not lasagna, California bread, and apple slate on 6/3/24 at 1:43 Pwould not be the bemechanical soft die be a choking proble recommend they not could guarantee it is	ropriate for a rest." and reads, "mediated potato with on meal, R21 restled potato with on meal, R21 restled ices. Ider sheet dated idet with mechanisms." on meal, R65 restled with skin, so meal, R65 restled vegetable ices. If M, V7 (RD) states ices.	ch soft eceived ham skin, spinach, ks. eceived meates, garlic 10/1/23 shows anical soft gular diet (with eceived a slice pinach, and eceived meates, garlic ted that ham esident on a quares could also uit unless they or them to eat.	S9999	DEFICIENCY)			
	Facility diet spreads mechanical soft res ground ham and a the skin.	idents should h	ave received					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '6) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		BEITH IO WIOW NOMBER.	A. BUILDING:	BUILDING:			
		IL6005144 B. WING		06/0	06/06/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CLARIDO	GE HEALTHCARE CE	NTER 700 JENK	ISSON UFF, IL 6004	14			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CO		(X5) COMPLETE DATE	
S9999	Continued From page 12		S9999				
	should follow the di diets.	PM, V4 (FSM) said the staff iet spread sheet for altered PM, V29 (Medical Director)					
	stated, "They definitely should be serving what is ordered for the resident's diets."						
	Diet Orders, Mecha 2017 states, " Pro altered by one of the	Jutrition Services Diets and anical Soft Diet policy dated ocedure: The texture may be ne following methods: Unless I, meat and meat substitutes y ground"					
	stated that he was qualifications a diet	AM, V29 (Medical Director) not familiar with what tary manager requires and he hat V4 (FSM) did not possess ttions.					
	Food and Nutrition "Qualifications: Cer American National accredited course a qualifications: Regi	b description for Director of Services dated 2018 states, rtified in food safety through an Standards Institute (ANSI) and has one of the following stered Dietitian, Licensed or Certified Dietary Manager"					
	remove the immediteam reviewed the unable to accept th immediacy. The abthe facility for revision second revised about the facility for revisions.	ed an abatement plan to iacy on 6/5/24. The survey abatement plan and was be plan to remove the patement plan was returned to ions. The facility presented a patement plan on 6/5/24 and the ted the abatement plan on					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6005144		B. WING		06/06/2024		
<u>'</u>				STATE, ZIP CODE		
CLARIDO	GE HEALTHCARE CE	NTER 700 JENK				
			JFF, IL 6004			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S9999	Continued From page 13		S9999			
	(A) Statement of Licensure Violations 3 of 3: 300.1210b) 300.1210c) 300.2040b)2)					
	Section 300.1210 General Requirements for Nursing and Personal Care					
	b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.					
		care-giving staff shall review ble about his or her residents' care plan.				
	Section 300.2040 Diet Orders					
	each resident, indic to have a general o	shall write a diet order, for ating whether the resident is r a therapeutic diet. The may delegate writing a diet n.				
	2) The diet sha	all be served as ordered.				
	Based on observat review the facility fa receiving a regular 3-ounce (oz) portion	are not met as evidenced by: ion, interview, and record illed to ensure residents texture diet received a n of sliced ham for the noon s applies to 4 of 4 residents				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005144	B. WING		06/	06/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, S	STATE, ZIP CODE			
CLARID	GE HEALTHCARE CE	NTER 700 JEN LAKE BL	KISSON ₋ UFF, IL 6004	14			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
\$9999	Continued From part (R44, R75, R84, R4 sample of 20. The findings included Facility provided Director R44, R75, R84, and texture diet. On 6/2/24 at 11:27 single slice of sliced a regular texture diet appeared small. The one quarter inch this by five-inch index of the continuation of additional ham during the continuation of the sizes served. On 6/2/24 at 12:37 was received and the tothe sizes served. On 6/2/24 at 12:54 used a calibrated for slice provided on the weighed 1.75 ozs (approximately 88 control provided to the sizes served.)	ge 14 45) reviewed for menus in the e: etary Type Report shows that d R45 all receive a regular AM, V12 (Cook) was placing a d ham on each plate receiving et. The slices of ham le slices were approximately lick and the size of a three inch ard or smaller. PM, V12 finished plating all the residents received ing normal meal service. PM, facility provided test tray the portion of ham was similar during lunch. PM, V4 (Dietary Manager) bod scale to weigh the ham le test tray. The ham slice bounces), providing alories and 11 grams (g) the residents were to receive a le which would provide calories and 20g protein. approximately 60 calories and	S9999				
	V12 cut the ham in 6/2/24.	PM, V9 (Cook) confirmed that to slices to serve for lunch on					
	Facility Diet Spread	Isheet shows the portion size					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005144	B. WING		06/	06/2024
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
CLARIDGE HEALTHCARE CENTER 700 JENKISSON LAKE BLUFF, IL 60044						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
\$9999	for the regular texture portion of ham. On 6/2/24 1:47 PM, sometimes he recestated the ham recehe was still hungry and the portion sizes set on 6/3/24 at 1:58 P the portion sizes set on 6/3/24 at 9:05 A not believe the food large enough. R75 6/2/24 and was still meal. R75 stated the	R44 said there are lives enough food, but he lived on 6/2/24 was small and lafter lunch. M, R84 state that he believes	S9999			

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