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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY VILLAGE	**612 WEST ST MARY'S STREET** **STERLING, IL 61081**

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F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH COMPLAINT # 0512326 300.1010 h) 300.1210 a) 300.1210b)1) 300.1210 b) 2)	F9999		

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300.1210 b) 3)

Facility staff shall notify the resident ' s physician of any accident, injury, or significant change in a resident ' s condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician ' s plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident ' s comprehensive assessment and plan of care. 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.

General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:
- Medications including oral, rectal, hypodermic, intravenous, and imtramuscular shall be properly administered.
- All treatments and procedures shall be administered as ordered by the physician.
- Objective observations of changes in a resident ' s condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the

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resident ' s medical record.

These regulations wet not met based on interview and record review which revelaed that the facility failed to:
[1] Have a system to correctly identify residents prior to the administration of medications.
[2] Respond to hypoglycemic episodes according to current practices.
[3] Nursing staff did not follow physician's orders when residents blood glucose levels fell below the established parameters.

This applies to 3 of 20 residents with diabetes in the facility (R30, R20, and R32).

These failures contributed to R30, having three significant episodes of hypoglycemia on 5/25/05, 5/26/05 and 5/27/05. R30 was hospitalized on 5/27/05 related to severe hypoglycemia.
On 5/28/05 R30 received insulin during the 5:00 PM medication pass causing another significant hypoglycemic episode.

The findings include:

R30 has diagnoses of Chronic Azotemia, Chronic Congestive Heart Failure, Diabetic Cardiomyopathy, Diabetic Neuropathy, Diabetic Gastroparesis, and Diabetic Nephropathy per Physician's Orders for May 2005. The Resident Assessment Tool is dated 6/10/05 & documents that R30 has no memory or cognitive deficits.

The Medication Administration Record (MAR) for May 2005 documents that R30 was started on Glyburide 5 mg twice daily on 5/24/05. Blood

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F9999	Continued From page 29 glucose monitoring is to be done twice daily. The physician is to be notified if the blood glucose level is below 70 or over 200. On 5/24/05 R30 received Glyburide 5 mg at 8:00AM. At 5:00PM R30's physician was notified related to a blood glucose level of 69. The physician ordered that the 5:00PM Glyburide be held because of R30's low blood sugar. On 5/25/05 at 6:00AM R30's blood sugar was 38. The MAR was blank on 5/25/05 and did not document whether R30 received the Glyburide or if it was held related to her low blood sugar. The 5:00PM dose of Glyburide was administered. On 5/26/05 R30's 6:00AM blood sugar was 48. At 8:00AM on 5/26/05, R30 received another dose of Glyburide 5 mg. There was no documentation on the MAR indicating whether R30 received the 5:00PM dose on 5/26/05. On the morning of 5/27/05 R30's blood sugar was 30 and the morning dose of Glyburide was held. R30's Nurse's Notes were reviewed from 5/24/05 to 5/28/05. There was no documentation in the Nurse's Notes that R30's physician was notified of her low blood sugars as documented on 5/25/05, 5/26/05 and 5/27/05. On 5/27/05 the Nurse's Notes state, "R30 is making a moaning sound. Blood glucose level was 30 gave resident juice with sugar and then fed her a small amount of butterscotch pudding. R30 is now talking to me ..." There were no blood glucose levels documented between 2:30AM and 6:15AM on 5/27/05. At 6:15 the Nurse's Notes state, "CNA came and got nurse, resident diaphoretic, not responding to nurse, blood glucose check 27, Blood Pressure 214/94, Pulse 90, and Respirations 22. Attempted to give Glucose 15 took small amount 911 called..."	F9999		

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On 5/28/05 R30 was discharged from the hospital and returned to the facility. R30's Short-Stay History and Physical Examination dated 5/28/05 states, "Impression: Hyperglycemia secondary to Glyburide."

The Medication Discrepancy Form dated 5/28/05 documents that at 5:00PM R30 received R31's medications to include: NPH Insulin 8 units, Humalog Insulin 4 units, Oscal 500 mg P.O. and Persantine 10 mg. E11 (LPN) documented that there were no name tags, no name on her chair, no name on her room door, no family with the patient, and no CNAs were available at the time of administration of the medications. R30 suffered a hypoglycemic episode related to this medication administration error.

Nurses Notes dated 5/28/05 document that R30 had a blood sugar of 42 at 7:00PM and 95 at 8:45PM.

The facility's Medication Administration-General Guidelines Policy states, "Residents are identified before medication is administered. When in doubt: Check identification band; Check photograph attached to medical record; If necessary, verify resident identification with other facility personnel."

On 6/21/05 at 1:30PM E2 (Director of Nurses) confirmed that residents did not have identification bands or pictures on their medical records. E2 also said that not all of the room doors have the resident's name on them. E2 stated, "E11 did not identify R30 prior to administering the wrong medications. E11

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should have found a staff member to help identify R30."

R20 had two instances in May where her blood glucose levels fell below the physician established parameters. R20's physician is to be notified if her blood glucose level falls below 60. On 4/10/05 R20's blood glucose level was 56. On 4/17/05 her blood glucose level was 47. There is no documentation in R20's clinical record indicating the physician was notified of these low blood glucose levels.

R32's physician wants to be notified if her blood sugar fall below 60. The May 2005 MAR documents that on 4/9/05 she had a blood glucose level of 55. R32's physician was never notified.

On 6/21/05 at 2:00 PM E2 (Director of Nurses) confirmed that the physician was not notified concerning the low blood sugar for R20 and R32. E2 stated, "The nurses know they need to call when it is specifically ordered in the physician's orders. Even if the physician does not order individualized blood sugar parameters we have standing orders which state call physician if blood sugar is below 60 or higher than 350."

The facility's Emergency Procedures for Hyperglycemia/hypoglycemia lacked instruction on the frequency of blood glucose testing after a resident displays hypoglycemia/hyperglycemia. The policy lacked current practice guidelines and interventions for residents with hypoglycemia.

STATE VIOLATIONS

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ASSOCIATED WITH COMPLAINTS
0512326, # 0512430, # 0512515,
0512556, & # 0512861.

300.610 a)
300.670j)
300.1220 b)
300.1220b)1)
300.1220b)2)
300.1220b)8)
300.2210a)
300.2210a)2)

The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician, or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Each facility shall establish and implement policies and procedures in a written plan to provide for the health, safety, welfare and comfort of all residents when the heat index/apparent temperature (see Section 300.Table D), as established by the National Oceanic and Atmospheric Administration, inside the residents' living, dining, activities, or sleeping areas of the facility exceeds a heat index/apparent temperature of 80 degrees F.

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The DON shall supervise and oversee the nursing services of the facility, including:

- Assigning and directing the activities of nursing service personnel.
- Overseeing the comprehensive assessment of the resident ' s needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
- Supervising and overseeing in-service education, embracing orientation, skill training, and on-going education for all personnel and covering all aspects of resident care and programming. The educational program shall include training and practice in activities and restorative/rehabilitative nursing techniques through out-of-facility training programs. This person may conduct these programs personally or see that they are carried out.

Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies.

Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

These regulations wet not met based on observation, interview and record review which revealed that the facility failed:
[1] To recognize a heat emergency and

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implement procedures to ensure the safety and well being of residents during a heat related situation when the cooling system was not functioning and room and hallway temperatures were above 80 degrees Fahrenheit (F), and
[2] To have a detailed written heat emergency plan in the event of a heat related emergency.

While this applies to all 96 residents the facility, 91 residents were specifically identified as at "high risk" for dehydration, heat stroke and heat exhaustion between 6/6/05 to 6/12/05. These residents were R1-2, R5-16, R18-30, R34-68, & R70-99.

The example includes:

On 6/12/05 at 1:30 PM during entrance tour R27 stated, "It is very warm in here." R34 stated, "It is very warm at night it is hard to get comfortable even with a fan." Z3 (family of resident) said that it has been extremely warm in the building the last 10 days.

On 6/12/05 at 3:00PM E1 (Administrator) said that they have had concerns about keeping the building cool for the past 10 days. We have had a very long period of hot, humid weather. We had portable units delivered on 6/3/05 in an attempt to stay on top of the situation. E1 stated, "It is very warm in here today." E1 said that on 6/3/05 they had a company from Chicago deliver six 5 ton cooling units and nine 1.5 ton cooling units to help keep the building cool. These units were vented into the ceiling or into empty rooms. The large 5 ton units put out a lot of heat. We could not keep the building cool. We are having our cooling tower repaired but it will take another

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F9999	Continued From page 35 2 weeks before we will have the parts. The facility's cooling system was not operational on 6/12/05. The facility's Maintenance Records show that the cooling towers were last inspected in October 1998 by the former maintenance man. E13 (Maintenance) started documenting maintenance on the cooling towers in November 2004. There was a 5-year, 11-month period when there was no maintenance documentation on either cooling tower. On 6/15/05 at 12:15 PM E13 stated, "The equipment has not been maintained the way you would think it should be. Filters were not changed as they should be. This type of equipment requires a lot of man time and maintenance." On 6/15/05 at 12:25 PM E14 (Maintenance) stated, "I started in my current position in late October of 2004. There were no maintenance records kept for the cooling towers prior to me starting in my new position. I followed the suggested maintenance intervals as printed in the Installation Operation Manual and Maintenance Manual. I powered the system up in late April of 2005 and we ended up with 3 feet of water in the boiler room. We were unable to repair the leaks. E1 (Administrator) was made aware that there was a major problem at that time. I had to shut the system down because we could not circulate water through the system. We did get several estimates on what it would take to repair the system. We are now waiting for parts which could take another 2 to 3 weeks to get here." On 6/22/05 at 9:00AM E13 and E14 verified that the environmental cooling towers have been shut	F9999		

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F9999	Continued From page 36 down since the end of April 2005. The system cannot be started back up until the coils have been manufactured and installed. Both said that since the shut down there has been no way to cool the building. E13 verified that it will take at least 2 weeks to get the parts to repair the cooling towers and that it could take longer than 2 weeks because a portion of the facility's roof has to be removed in order to get the new parts into the boiler room. From 6/6/05 to 6/12/05 resident room temperatures were not monitored. Documentation dated 6/10/05 shows that the average temperature on 200-wing was 86 degrees Fahrenheit (F); on 300-wing the average temperature was 88 degrees F; and on the400-wing temperatures averaged 89 degrees F. On 6 /12/05 at 1:30PM the building felt uncomfortably warm inside. On 6/12/05 room temperatures were measured and found to be between 81 to 88 degrees F. The facility had no way to cool the building at that time because of cooling tower equipment failure. According to facility temperature records the average temperature that day on the 200-wing and 400-wing was 84 degrees F. The average temperature on the 300-wing was 85 degrees F. It was 88 degrees F at the Nurses Station and lounge area on the Health Care Unit. The Weather Underground History for Sterling, Illinois documented that the outside temperature trend for 6/1/05 through 6/12/05 was in the mid to upper 80's. On 6/4/05 the outside temperature was 93 degrees Fahrenheit. On 6/17/05, the facility provided documentation	F9999		

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F9999	Continued From page 37 that they identified 21 residents who are at risk in a heat related emergency. Review of the facility's criteria for residents at risk and listings of residents ' age, diagnoses and medications provided on 7/15/05, found there are 91 residents who have some degree of risk in a heat related emergency. On 6/12/05 at 4:00PM E1 (Administrator) was asked for a copy of the facility's emergency plan related to heat emergencies. At 10:30PM when the survey team left the building no evacuation plan had been provided by administration. On 6/21/05 E1 and E2 were asked by the survey team for a copy of the facility evacuation plan. E 1 stated, "I could not find a copy of the policy and procedure in the building. Corporate office sent a copy of the current evacuation plan. The plan as it is right now is in definite need of revision." The facility's Disaster Preparedness Plan received 6/14/05 fails to include how staff is to be instructed on heat related emergency procedures & heat related evacuation procedures. The policy had no instructions/guidelines for what point a heat emergency exists, temperature guidelines for hot weather or expanded criteria for residents at risk for heat related problems. The policy states did give instructions for cold related emergencies only.	F9999		