STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145307	A. BUILDING _____ B. WING _____	07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER - LA GRANGE	**701 NORTH LAGRANGE ROAD LA GRANGE PARK, IL 60526**

(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 371	Continued From page 22 -On 7/10/2007 at 10am, the surveyor observed the 3-compartment sink was set for manual washing. The surveyor observed cookware items within each of the sink compartments. The surveyor asked E8 to check in the final compartment for the sanitation concentration. The surveyor asked what chemical was used to sanitize. The surveyor was told it was chlorine. E8 used the chlorine strip and it turn slightly. This was checked against the color chart and it was at 10ppm. E8 commented to the surveyor the strip had turn 200ppm, pointing to the end of the strip, which was being held in her hand. The surveyor asked E8 and the cook present in the area, what should the concentration of the sanitizer be. The surveyor was told 200ppm. The surveyor took a second chemical strip and re-checked the concentration. This strip did not reach 10ppm. The required concentration for a chlorine concentration is 50ppm.	F 371		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.670j) Section 300.670 Disaster Preparedness j) 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/apparent temperature of	F9999		

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F9999	Continued From page 23 80 degrees F. This Requirement is not met as evidenced by the following: Based on observations, interviews and record reviews the facility failed to ensure that a comfortable and safe temperature level was maintained during extreme heat, failed to implement an effective hot weather policy, failed to monitor residents at risk for heat exhaustion, and failed to maintain the equipment and the building to prevent excessive heat. This failure resulted in 40 residents in the facility (out of 84) being exposed to prolonged heat and humidity during July 7, 8 and 9, 2007. Findings include: During the orientation tour of the facility on July 9, 2007 at 10:43am it was noted that the third floor was extremely warm and residents were noted to complain about the temperature. The third floor houses 40 residents and is a closed unit with numerous confused residents. Many of the residents on the third floor are cognitively impaired. It was noted that drapes were open, all the hallway lights were on and only some fans were operating. Temperatures were taken on the unit with the facility thermometer in the presence of E7 (Housekeeping Supervisor) and E5 (Nurse) with the following results: Room 314 85.5 degree F (Farenheit) 58% Humidity Room 307 86.8 degree F 54% Humidity Room 311 87.1 degree F 56% Humidity Hallway 88.6 degree F 55%	F9999		

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F9999	Continued From page 24 Humidity Room 312 88.6 degree F 55% Humidity Main Dining 88.0 degree F 54% Humidity After prompts by surveyor, the staff proceeded to close the curtains, run all fans on the unit and turn off some overhead lights. Z2 (family member) complained to surveyor during the tour about the level of heat in the facility. Z2 stated that she had complained to E2 (Director of Nursing) and E1 (Administrator) about the heat in the room and nothing had been done. Z2 stated that the facility was very hot over the weekend (July 7 and July 8). R4 also complained to surveyors about the heat. R4 was noted to be short of breath and also stated that it had been very hot over the weekend. During the lunch meal, surveyors returned to the 3rd floor and noted that the windows in the Dining Room were not completely closed. A flow of hot air was noted to stream into the area. In addition the heating/air conditioning unit was not working. Residents were noted to be eating on their trays with no additional water on the tray. Staff did not encourage or prompt residents to consume additional fluids. Surveyor asked E5 (nurse) for a list of residents considered to be at high risk for heat problems and E5 responded, "we don't have one." E5 was also asked about what methods were being used for monitoring residents and E5 stated, "we will monitor the vitals and offer fluids." Temperatures were taken on the unit again with	F9999		

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F9999	Continued From page 25 the facility's thermometer at 12:05 to 12:30pm with the following results: Dining Room 86.4 degree F Room 314 87.3 degree F Room 307 87.3 degree F Room 308 87.7 degree F Surveyor returned later with E6 (Maintenance Director) and re-tested the temperature. E6 stated that the thermometer being used was not the correct type to use to measure heat. E6 returned with two other thermometers and all three were placed in the same area to measure the temperature. The temperatures were within 1 to 2 degrees. The dining room remained at 86 to 88 degree F. It was also noted that many of the heat/air conditioning units were not functioning at all. Warm air was noted coming out of the units not cool in rooms 314, 307, 308 and the dining room. E6 stated that he would place the thermometer in the cooling unit itself and take the reading. In addition, the regular monitoring was done by thermometers placed in the hallways and dining room. Routine monitoring of rooms with malfunctioning units was not being done by staff. E6 also stated that numerous units were not working and that they had ordered parts and replacements. E6 stated that these replacements have not arrived. E6 indicated he knew the rooms with malfunctioning units and had placed fans in the rooms. E6 confirmed that he did not regularly take temperatures of those rooms. E10 (Social Service Director) was interviewed by surveyor on July 9, 2007 about heat monitoring. E10 stated that she had been the manager on duty the previous weekend and had only taken temperatures in the hallway. E10 stated that she	F9999		

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F9999	Continued From page 26 did not take temperatures in individual rooms. E1 (administrator) was interviewed about the heat problem and stated on July 9, 2007 at 1:15pm that July 9, 2007 was the first day it was really hot. E1 stated they (meaning the staff) were monitoring the residents and keeping residents out of the hot areas. E1 also stated that the facility had ordered new heat/cooling units in April, but they still had not arrived. E1 was asked about what level of temperature would cause concern and a need for action and E1 responded, "temps above 85 degree F." E1 was advised that several rooms on the third floor along with some of the common areas were above 85 degree. E1 responded that she would remove the residents. Later, E6 and the surveyor returned to the third floor and temperatures were still noted to be over 85 degrees in numerous areas. Again, E6 stated that we were not measuring the temperature correctly. E6 wanted to use a food stem thermometer and place it directly into the heating/cooling unit. E6 was not reading the actual room temperature. At this time, the survey team requested a list of high risk residents for heat and the facility's policy for heat emergencies. The initial list of residents included only 7 of 40 residents. The facility did not include residents over the age of 65, residents receiving diuretic medications, and residents receiving psychotropic medications. Once updated, 38 out of 40 residents were identified as being at risk for heat related problems. A review of the facility's policy for "Weather Emergencies - Hot and Cold" states the following:	F9999		

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F9999	Continued From page 27 "Maintenance to check temperature readings throughout the facility in resident and nonresident areas" "Relocate to the coolest part of the building" "Nursing staff to encourage fluids" "Close shades, drapes, windows during 10:00am to 6:00pm" "Turn off lights" During the group interview on July 10, 2007, residents stated that the facility was extremely hot the last few days. All residents present in the group stated that on July 7, July 8 and July 9 the temperatures were "excessive", "really hot" and "unbearable." Residents at the group meeting stated that the only cooling measure offered to residents was the addition of fans. Residents complained that the heating/cooling units did not work and in fact hot air was blowing into rooms from the unit. Residents also stated that in June of 2007 during another hot spell it was very hot and they had complained and nothing had been done. Interview with Z3 (family member) indicates that this family member had complained about the heat in June and that over the weekend the facility was, "very hot." Z3 stated that the first and third floors were very hot. Resident and staff interviews also confirmed that the facility had been very hot and uncomfortable July 7, 8 and 9th. Residents stated that E6 and E7 did place fans, however the air conditioning was not working and the facility was very warm. A review of weather monitoring by "Weather Underground" indicates the temperature in	F9999		