STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145527	A. BUILDING _____ B. WING _____	07/15/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT HLTH CR CTR-NORTHBRK	2155 PFINGSTEN ROAD NORTHBROOK, IL 60062

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F 000	INITIAL COMMENTS Annual Licensure & Certification Extended survey conducted. Validation Survey for Subpart U: Covenant Healthcare Center of Northbrook is in compliance with Subpart U, 77 Illinois Administrative Section 300.7000, for this survey.	F 000		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that 4 residents (R8, R9, R14, and R20) were provided with acceptable standards of professional practice in the following areas: 1. Not updating the physician in a timely manner regarding R9's swollen extremities and failed to provide an ongoing assessment for the swollen extremities. 2. Not following physician order for R8's diet order. 3. Not following physician order for R14's oxygen administration. 4. Not following physician order for R20's nutritional supplement.	F 281		8/15/08

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 281	Continued From page 1 Findings include: 1) Review of the nurse's notes dated 5/8/08 showed that R9 was afraid to ambulate due to the pain in the right knee area. Further review of this nurse's notes also indicated that R9 was observed with swollen knee. As per record, R2's attending physician was informed and that x-ray of the knee was obtained. Further review of the nurse's notes indicated that on 6/14/08, R9 was "noted with swelling of both knees to ankles." Review of clinical record showed that there was no documentation that R9's swollen extremity was monitored after it was identified on 5/8/08. Again, after R9's was again observed on 6/14/08 with swollen knees to ankles, there was no monitoring for this swelling until R9 was seen by the attending physician on 6/23/08. Record showed that on 6/23/08, R9's attending physician came to the facility and saw R9. Review of physician progress notes dated 6/23/08 showed that R9 has "complained of on-going bilateral knee pain as well as onset of leg swelling." Further review of the physician progress notes showed that an order for x-ray was done and a low dose of antidiuretic with potasium supplement was ordered to control leg edema. There was no indication that a timely follow-up with attending physician was done when R9's was noted again with swollen legs on 6/14/08 .	F 281		

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F 281	Continued From page 2 There was also no documentation that there was continued monitoring with assessment regarding R9's swollen legs. 2) Review of current physician order showed that R8 has an order for "pureed diet; may have mechanical-soft solids if fork mashable and does not crumble." Review of R8's current care plan also indicated this current physician order regarding R8's diet order. R8 was observed on 7/13/08 at 12:15 P.M. being assisted for lunch meal by E6 (certified nurse assistant). During the lunch observation, R8 was served with pureed diet consistencies. E6 confirmed that R8 had always been served with pureed diet consistencies and that "it has been a while that (R8) was served with mechanical-soft or ground meat." 3) R14 was observed on 7/13/08 at 1:20 P.M. during the medication pass observation with E3 (nurse). R14 was in bed and was not administered with oxygen. At this time of observation, E3 turned the oxygen concentrator and administered oxygen at 2 liters per nasal cannula to R14. R14 was again observed on 7/14/08 from 12:40 P.M. and at 1:45 P.M. At this time of observation, R14 was receiving her physical therapy treatment being provided by E7 (physical therapist) . R14 was again disconnected from her oxygen treatment.	F 281		

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F 281	Continued From page 3 Review of current POS (physician order sheet) showed that R14 has an order for "Oxygen at 2 liters per nasal cannula; check oxygen saturation every shift, titrate off to keep oxygen saturation at above 92%." 4) During medication pass observation on 07/13/08 at 9 AM, E4 (Nurse) gave R20's medications which includes: -Oyster Shell 500 mg. 1 tab -Tylenol 325 mg. 2 tabs -Vitamin D 400 1/2 tab x 5 tabs -Sertraline 50 mg. 1 tab -Enalapril 10 mg. 1 tab -Folbic acid 2.5 mg. -Ferrous Gluconate 324 mg. 1 tab -Ascorbic acid 250 mg. 1 tab -Aricept 10 mg. 1 tab -Lasix 40 mg. 1 tab -Namenda 10 mg. 1 tab -Aspirin 81 mg. 1 tab -2 Cal HN 90 cc -Potasium Chloride 10% (20 meq.) 15 cc During reconciliation of orders, R20 was noted with a physician order for "Two Cal HN at 1/2 a can twice a day." When E4 gave R20 the 90 cc Two Cal HN, a high calorie nutritional supplement, it was observed that a whole can of this high calorie nutritional supplement was 237 cc . E4 only gave R20 a 90 cc as observed.	F 281		
F 323 SS=J	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident	F 323		8/15/08

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F 323	Continued From page 4 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to maintain and monitor the hot water in a temperature which is safe for the residents, the staff, and the public to use. This condition resulted in an Immediate Jeopardy which was announced at approximately 12:20 P.M. on July 12, 2008. Findings include: On July 12, 2008 at approximately 12:10 P.M., the hot water in the employee wash room felt very hot. Employee 5 (Maintenance Director) was immediately called. In the presence of E5 and, with the use of a dial thermometer, the hot water distribution in the residents handwashing sinks measured between 138 to 140 degrees Fahrenheit. Hot water temperature readings were taken at the 300, 200, and 400 wing, and all readings were consistent between temperatures of 138 to 140 degrees F. When investigated, the temperature reading on the mixing valve, located in the boiler room, was between 120 and 140 degrees F. According to E5, the mixing valve handle was accidentally moved, when bumped into, during the time when	F 323		

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F 323	Continued From page 5 the air handler on the roof of the building was being fixed. This happened a week before, E5 added. As a result, the temperature of the water at the mixing valve was raised to unsafe levels. Review of the facility hot water monitoring log sheet, beginning the month of July of 2008, revealed that the hot water temperatures have already exceeded acceptable parameters. Records showed temperature reading of 117, 118, and 120 as randomly measured by a maintenance staff. Readings were taken from resident's washroom sinks and common shower rooms. No adjustments were made to lower the temperature of the hot water, according to facility records and according to E5 when interviewed. Once announced, E1 (Administrator) implemented the following abatement plan and interventions. 1. Signs were posted prohibiting the use of the hot water. 2. Staff members assigned to go door to door throughout the building to check all faucets and and tag any faucets that exceeded the temperature limit of 110 degrees. 3. Skin and nursing assessments to all residents. (No residents were determined to have been affected when assessments were completed.) 4. Created an emergency plan to check all water dispensing locations with the use of a Water Monitoring log. Hot water temperatures were measured in at least three different rooms and shower areas every 15 minutes until 3:00 P.M. on	F 323		

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F 323	Continued From page 6 7-12-08 and then reduced to every 30 minutes every hour thereafter until 7 A.M. on 7-13-08. The frequency of monitoring was reduced once acceptable temperature levels were reached. These were all noted on the temperature logs. 5. A protective cover over the water mixing valve was installed by the maintenance department so as to prevent accidental change of valve position and setting. This was completed on 7-12-08 at 5:00 P.M. 6. The Daily Reading log form was modified to identify clearly the maximum and minimum temperature requirements. The modified form now includes the procedure to inform the head of maintenance department, the Administrator, and the Director of Nursing if temperatures are outside the permissible parameters. The revision of the form was completed on 7-12-08 at 6:00 P.M. 7. The Daily Water Reading Log form will be reviewed daily by the maintenance director four times/week to ensure compliance with the documentation process and to monitor trends/patterns in temperatures obtained. 8. All staff were inserviced on 7-12-08 and 7-13-08 regarding guidelines on appropriate water temperatures including the monitoring and communication systems to follow. 9. The Quality Assurance department developed a QA tool to evaluate the monitoring process. The QA audit will be completed once a week (for four weeks), then monthly (for four months), and then quarterly thereafter. The maintenance director and/or designee have been designated	F 323		

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F 323	Continued From page 7 to coordinate the monitoring process. The maintenance director will report the progress and effectiveness of the process directly to the Administrator and to the Quality Assessment and Assurance Committee. 10. The Audits will commence on the week of July 21, 2008, and then on-going as planned. 11. The Administrator will ensure compliance of the above plan. The Immediate Jeopardy was initially abated on July 12, 2008 soon after it was announced at 12:20 P.M. and completed the abatement at 5:00 P.M. after the above procedures were implemented.	F 323		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations of the medication pass, review of clinical records, and staff interviews, the facility failed to ensure that it is free of a medication error rate of five percent or greater by failing to administer medications as ordered by the physician. There were 40 opportunities observed with a total of 4 errors. This resulted in a medication error rate of 10 % (R2, R16 and R20). Findings include: 1.) During medication pass observation on	F 332		8/15/08

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F 332	Continued From page 8 07/13/08 at 9 AM, E4 (Nurse) gave R20's medications which includes: -Oyster Shell 500 mg. 1 tab -Tylenol 325 mg. 2 tabs -Vitamin D 400 1/2 tab x 5 tabs -Sertraline 50 mg. 1 tab -Enalapril 10 mg. 1 tab -Folbic acid 2.5 mg. -Ferrous Gluconate 324 mg. 1 tab -Ascorbic acid 250 mg. 1 tab -Aricept 10 mg. 1 tab -Lasix 40 mg. 1 tab -Namenda 10 mg. 1 tab -Aspirin 81 mg. 1 tab -2 Cal HN 90 cc -Potasium Chloride 10% (20 meq.) 15 cc During reconciliation of orders, R20 was noted with a physician order for Potasium Chloride 10% (20 meq.) 15 cc to be mixed in 4-8 oz. water or juice. Review of the the medication label also showed that this Potasium Chloride should be diluted with 4-8 ounces of water. When E4 gave R20 the undiluted Potasium Chloride 10%, R20 stated to E4 "I cannot finish this, this is terrible". R20 did not take the full prescribed dose for Potasium Chloride and had left approximately 5 cc of this medication in the medication plastic cup. 2.) During medication pass observation on 07//13/08 at 9:35 A.M., E4 (Nurse) gave R16's medications which includes: -Enteric Coated 81 mg. 1 tab -Cozaar 50 mg. 1 tab. -Plavix 75 mg. 1 tab	F 332		

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F 332	Continued From page 9 -Multivitamin 1 tab. -Megace 10 cc. -Carafate Suspension 10 cc. Review of POS (Physician Order Sheet) reflected that R16 was noted with a physician order for "Carafate Suspension; Shake well before using; Take 10 mls. by mouth before meals and at bedtime." E4 failed to shake the Carafate Suspension bottle before medication preparation and administration to R16. Furthermore, R16 already was at the activity room during the medication administration and had finished her breakfast. 3.) During medication pass observation on 07/13/08 at 12:20 P.M., E3 (nurse) administered R2's medication (Cardizem 60 mg. 1 tablet) via R2's gastrostomy tube. E3 crushed the Cardizem tablet, diluted this crushed medication with 15 cc of water, then administered thru R2's gastric tube. E3 failed to flush the gastric tube prior to medication administration. Review of the facility's policy for medication administration via gastric tube showed to flush the gastric tube with water prior to medication administration.	F 332		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)6) 300.3130c)4)5)	F9999		

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F9999	Continued From page 10 Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3130 Plumbing Systems c) Water Supply Systems 4) Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit. 5) Protective measures, such as but not limited to, installation of a mixing valve, limited access to controls, and checking water temperatures daily at various points, shall be implemented to insure that the temperature of hot water available to residents at shower, bathing	F9999		

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F9999	Continued From page 11 and handwashing facilities shall not exceed 110 degrees Fahrenheit. These REGULATIONS are not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to maintain and monitor the hot water in a temperature which is safe for the residents, the staff, and the public to use. Findings include: On July 12, 2008 at approximately 12:10 P.M., the hot water in the employee washroom felt very hot. Employee 5 (Maintenance Director) was immediately called. In the presence of E5 and, with the use of a dial thermometer, the hot water distribution in the residents handwashing sinks measured between 138 to 140 degrees Fahrenheit. Hot water temperature readings were taken at the 300, 200, and 400 wing, and all readings were consistent between temperatures of 138 to 140 degrees F. When investigated, the temperature reading on the mixing valve, located in the boiler room, was between 120 and 140 degrees F. According to E5, the mixing valve handle was accidentally moved, when bumped into, during the time when the air handler on the roof of the building was being fixed. This happened a week before, E5 added. As a result, the temperature of the water at the mixing valve was raised to unsafe levels. Review of the facility hot water monitoring log sheet, beginning the month of July of 2008, revealed that the hot water temperatures have	F9999		

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F9999	Continued From page 12 already exceeded acceptable parameters. Records showed temperature readings of 117, 118, and 120 as randomly measured by a maintenance staff. Readings were taken from residents' washroom sinks and common shower rooms. No adjustments were made to lower the temperature of the hot water, according to facility records and according to E5 when interviewed. (A)	F9999		