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	14E242	A. BUILDING _____ B. WING _____	07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELTERING OAK	P O BOX 367 ISLAND LAKE, IL 60042

(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 518	Continued From page 14 transport or overnight shelter. I did not know IDPH had to be notified if temperatures exceed 81 degrees Fahrenheit." On 07/19/12 between 2:30 PM and 4:00 PM, all employees (E4-E8 (all CNAs) and E3-E4 (RN)) interviewed stated the facility had not provided any formal training on disaster preparedness or provided information on the evacuate residents from the facility in the event of an emergency.	F 518		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.670a) 300.670e) 300.670j) Section 300.670 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. e) The facility shall provide for the evacuation of physically handicapped persons, including those who are hearing or sight impaired. 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	F9999		

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F9999	Continued From page 15 established by the National Oceanic and Atmospheric Administration, inside the facility exceeds 80°F. 300.3120 Section 300.3120 Mechanical Systems h) Heating, Ventilating, and Air Conditioning Systems 1) Areas of a nursing home used by residents of the nursing home shall be air conditioned and heated by means of operable air-conditioning and heating equipment. The areas subject to this air-conditioning and heating requirement include, without limitation, bedrooms or common areas such as sitting rooms, activity rooms, living rooms, community rooms, and dining rooms. B) The air-conditioning system shall be capable of maintaining an ambient air temperature of between 75 degrees Fahrenheit and 80 degrees Fahrenheit, THIS REQUIREMENT WAS NOT MET AS EVIDENCED BY: Based on observation, interview, and record review the facility failed to maintain safe and comfortable air temperature.This failure resulted in a heat index of 90 to 106 degrees F inside the building. This created a hazardous environment for the residents who were at increased risk for heat stroke, heat exhaustion and dehydration. This failure existed for six (6) days. This applies to 55 of 55 residents in the facility The findings include:	F9999		

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The facility data sheet of 07/12/12 shows the facility census of 55.

Weather Underground (www.wunderground.com) information shows the average outside air temperatures at the closest airport to Island Lake from July 1 to July 6 ranged from 82 to 92 degrees F (Fahrenheit). The high temperatures ranged from 92 to 104 degrees F. The highest heat index was between 127 and 181 degrees F.

On 07/05/12 at 3:00 PM, when surveyor entered the facility, there was no discernible difference in temperature from the outside. When touring the building the thermometer/hygrometer at the nursing station showed a temperature of 86 degrees F with a relative humidity of 68 percent. The heat index was 94 degrees F. The only other thermometer in the facility was on a resident hallway and read 92 degrees F. Combined with the relative humidity of the building the heat index was 111 degrees F.

As of 7/5/12, The facility did not have any temperature logs and was not monitoring the air temperature of the building. On 07/19/12 between 2:30 PM and 4:00 PM, employees confirmed the facility did not begin taking or logging temperatures until after the Illinois Department of Public (IDPH) Heath entered the building on 7/5/12. On 07/18/12 at 2:30 PM, E1 (Administrator), stated, "I do not know when temperatures were outside of a safe range. I did not know the policy for temperature monitoring. The maintenance man should have been monitoring temperatures and he was not. We should have been taking temperatures. When

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F9999	Continued From page 17 the temperatures were out of range we should have notified IDPH and called for guidance." On 07/05/12 at 3:00 PM, Surveyor asked E1 (Administrator) for a plan to cool the building and a evacuation plan in case the residents had to be relocated. E1 was unable to provide a detailed evacuation plan in case of emergency. Hourly temperatures were taken in the facility between 12 Noon and 7:00 PM on 7/5/12 by survyor. Temperatures ranged from 83 to 92 degrees Fahrenheit in resident occupied areas. Facility temperature logs From 6:30 PM to 11:30 PM on 7/5/12 showed for each zone in the building:: Zone 1 - Highest temperature was 89 Degrees F at 7:00 PM with temperatures ranging as low as 85 degrees F. Zone 2 - highest temperature was 89 degrees ranging as low as 85 degrees F. Zone 3 - the highest temperature was 89 with temperatures ranging as low as 84.9 degrees F. Zone 4 -the highest temperature was 89.8 degrees with temperatures ranging as low as 83.6 F. The relative humidity was 52 to 74 percent. The resulting heat index ranged from 90 to 106 degrees F. On 7/6/12 between 12:00 AM to 5:00 AM each zone's temperatures were: Zone 1- 88.3 to 86.9 degrees F ,.Zone 2 - 88 to 86 degrees F, Zone 3 - 88.5 to 86.5 degrees F and Zone 4 - 88.5 to 85.8 degrees F. The relative humidity was 52 to 74 percent. The resulting heat index ranged from 88.9 to 106 degrees F.	F9999		

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On 07/17/12 between 2:00 PM and 4:00 PM, the following comments were made by residents: "It was tough for sleeping, I slept on a mattress on the floor;" "It was warm, and they never told us how hot it was. I could string up the owner of that place;" "The environment was very uncomfortable. We couldn't sleep because it was sticky and humid. It was too hot to do any normal activities, so we just rested." "We were dying from the excessive heat. I complained to the nurse on duty. We had fans but they didn't help. We were unable to sleep. I was so tired so clammy, and couldn't do anything. We sat in the eating room because it was the only room with air-conditioning and it wasn't very cool there."

The July 2012 physican order sheets for all 55 residents showed that 54 of 55 residents were recieving antipsychotic medications (all but R14) and 15 were on diuretics (R2, R4,R6,R15, R17, R18, R22, R23, R31,R37, R38, R41,R 45, R50, R51).Residents recieving antipsychotic and diuretics medications are at increased risk for dehydration.

On 07/05/12 at 7:45 PM, portable air-conditioning units were delivered to the facility.

The residents were evacuated to the Island Lake Village Hall on 07/06/12 at 2:00 PM by order of Z1 related to extreme heat conditions and increased risk of fire related to overloaded electrical panels. Z1 explained, Z5 (Lieutenant with Island Lake Fire Department) agreed the building was unsafe and the residents had to be moved.

The residents were evacuated to the Island Lake

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Village Hall on 07/06/12 at 2:00 PM, by order of the Island Lake Chief of Police. On 7/18/12 at 8:55 AM, Z1 (Chief of Police) stated, "[On Friday 07/06/12,] I walked in the facility between 11:30 AM and 12:45 PM to follow up from a call I received the night before. The facility had come up with a resolution to the heat. They had portable air-conditioning units running since 12:00-1:00 AM. The cooling units were not effectively cooling the building. When I walked in form outside it was extremely hot; I was pouring sweat within 10 minutes. It was just as hot inside as it was outside. The administrator showed me the cooling units. There was water pooling on the floor next to an electrical outlet. The cardboard used to seal the windows was wet and falling off. There was a resident laying on the floor (who) was was visibly overheated. I asked to see the electrical boxes. I placed my hand on the boxes and they were hot to touch. The panels were dangerously hot. The fire department was called and the fire department used a thermal imager to read the temperature of the breaker panel. The panel read 150 degrees F. The Fire Department agreed the building was unsafe and the residents had to be moved."

On 07/19/12 at 2:00 PM, Z7 (Building Inspector) stated, "There was an increased risk of fire related to the overloaded breakers. It could have been dangerous because of the additional air-conditioning units."

On 07/20/12 at 10:100 AM, Z5 (Lieutenant with Island Lake Fire Department) stated, "The electrical panels were hot to touch. Many circuits

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F9999	Continued From page 20 had already tripped. The building was not engineered for the additional load [from newly installed portable air-conditioning units] which overloaded the system." On 07/18/12 at 2:30 PM, E1 stated, "I do not have a copy of any agreements for evacuation with another facility. I didn't know the resources that were available. Had I known I would have notified IDPH [Illinois Department of Public Health]." On 07/18/12 at 8:55 AM, Z1 (Police Chief) stated, "[On 07/06/12 at 12:00 PM] I asked the administrator [E1] if he was in need of help to move the residents. [E1] responded 'my hands are tied.' He then shrugged his shoulders. I asked the administrator if he had and operations plan and he responded 'no.'" On 07/19/12 at 10:50 AM, Z4 (Lake County EMA Coordinator) stated, "The worst case scenario would have been if the electrical system would have failed resulting in a fire. Because of this risk, it required an emergency evacuation which could have resulted in serious harm to the residents in the facility. The first responders had to develop an evacuation plan. The evacuation [of residents] was delayed because the facility did not have a plan in place. It put the residents at unnecessary risk and could lead to serious harm or death." (B) 300.610a)	F9999		

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F9999	Continued From page 21 300.610c)1) Section 300.610 Resident Care Policies a) 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. c) These written policies shall include, at a minimum the following provisions: 1) Admission, transfer, and discharge of residents including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers THIS REQUIREMENT WAS NOT MET AS EVIDENCED BY: Based on interview and record review the facility administrator failed to ensure the facility had a heat emergency plan to include evacuation and relocation of residents in the event of an emergency. The administrator allowed residents to stay in the building when interior temperatures	F9999		

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became critical. The administrator also exposed residents to additional risks including potential electrical failure and potential fire hazards. These failures occurred over a period of six (6) days.

This applies to 55 of 55 residents in the facility

The findings include:

The facility data sheet of 07/12/12 shows the facility census of 55.

On 07/18/12 at 8:55 AM, Z1 (Police Chief) stated, "[On 07/06/12 at 12:00 PM] I asked the administrator [E1] if he was in need of help to move the residents. [E1] responded 'my hands are tied.' He then shrugged his shoulders. I asked the administrator if he had an operations plan and he responded 'no.'"

The residents were evacuated to the Island Lake Village Hall on 07/06/12 at 2:00 PM by order of Z1 related to extreme heat conditions and increased risk of fire related to overloaded electrical panels. Z1 explained, Z5 (Lieutenant with Island Lake Fire Department) agreed the building was unsafe and the residents had to be moved.

On 07/18/12 at 10:25 AM, Z3 (Emergency Management Agency (EMA) Coordinator for Island Lake) stated, "We were first notified on Thursday evening [07/05/12] of a possible need to evacuate the facility's residents. The next call was at 1:30 PM on Friday [07/06/12] that there was going to be an evacuation. The only staff at the evacuation site was myself and my

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grandchildren because of the lack of notice. I could have notified EMA volunteers and village staff had I been notified sooner. I am not aware of any long-term evacuation plan. We could provide a place for a maximum of twenty-four hours. Had the facility [administrator] notified us prior to the building reaching unsafe levels, we could have contacted Lake County EMA and prevented the need to evacuate the residents."

On 07/19/12 at 10:50 AM, Z4 (Lake County EMA Coordinator) stated, "We like to be notified prior to conditions reaching unsafe levels. If the facility had an inkling they were not able to maintain safe conditions we should be notified. If they were unable to maintain safe temperatures for multiple days without night-time cooling we should have been notified. Had we been notified we would have worked with the facility to develop a plan to cool the building, allowing the residents to stay in place. We would have used external air-conditioning units and generators - not having to utilize the facility's internal structures or wiring. The worst case scenario would have been if the electrical system would have failed resulting in a fire. Because of this risk, it required an emergency evacuation which could have resulted in serious harm to the residents in the facility. The first responders had to develop an evacuation plan. The evacuation [of residents] was delayed because the facility did not have a plan in place. It put the residents at unnecessary risk and could have led to serious harm or death."

On 07/18/12 at 2:30 PM, E1 stated, "I do not have a copy of agreement for evacuation with any facility. No outside agencies were notified prior to IDPH [Illinois Department of Public Health]

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coming into the building. We did not notify IDPH or call for assistance. Temperatures in the building were not being monitored. I didn't know the [emergency] resources that were available. Had I known I would have notified IDPH." E1 did not provide any documentation of staff training related to emergency preparedness and evacuation of residents.

The facility Administrator Job Description (dated 7/18/12) states, "Purpose of Your Job Position: The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times... Administrative Functions: Review the facility's policies and procedures periodically, at least annually, and make changes as necessary to assure continued compliance with current regulations. Represent the facility in dealing with outside agencies, including governmental agencies and third party payers... Ensure that public information (policy manuals, etc.,) describing the services provided in the facility is accurate and fully descriptive. Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed." (pp. 1-2) The same description states, "Assure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. Assure that each resident receives the necessary nursing, medical, and psychosocial services to attain and maintain the highest possible mental and physical

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F9999	Continued From page 25 functional status, as defined by the comprehensive assessment and care plan." (p. 5) (B) 300.650f)1)2) Section 300.650 Personnel Policies f) Orientation and In-Service Training 1) All new employees, including student interns, shall complete an orientation program covering, at a minimum, the following: general facility and resident orientation; job orientation, emphasizing allowable duties of the new employee; resident safety, including fire and disaster, emergency care and basic resident safety; and understanding and communicating with the type of residents being cared for in the facility. In addition, all new direct care staff, including student interns, shall complete an orientation program covering the facility's policies and procedures for resident care services before being assigned to provide direct care to residents. This orientation program shall include information on the prevention and treatment of decubitus ulcers and the importance of nutrition in general health care. 2) All employees, except student interns shall attend in-service training programs pertaining to their assigned duties at least annually. These in-service training programs shall include the facility's policies, skill training and ongoing education to enable all personnel to perform their duties effectively. The in-service training sessions	F9999		

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regarding personal care, nursing and restorative services shall include information on the prevention and treatment of decubitus ulcers. In-service training concerning dietary services shall include information on the effects of diet in treatment of various diseases or medical conditions and the importance of laboratory test results in determining therapeutic diets. Written records of program content for each session and of personnel attending each session shall be kept.

THIS REQUIREMENT WAS NOT MET AS EVIDENCED BY:

Based on interview and record review the facility failed to have procedures for a heat emergency and failed to train staff to prepare them for an emergency resident evacuation and relocation from the facility. This failure resulted in a delay of the evacuation of residents from critically high temperatures in the building for six (6) days.

This applies to 55 of 55 residents in the facility

The findings include:

The facility data sheet of 07/12/12 shows the facility census was 55.

On 07/05/12 at 3:00 PM, when surveyor entered the facility there was no discernible difference in temperature from the outside. When touring the building the thermometer/hygrometer at the nursing station showed a temperature of 86 degrees F with a relative humidity of 68 percent. The heat index of 94 degrees Fahrenheit (F). The only other thermometer in the facility was on

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a resident hallway and read 92 degrees F. Combined with the relative humidity of the building the heat index was 111 degrees F.

On 07/05/12 at 3:00 PM, Surveyor asked E1 (Administrator) for a plan to cool the building and a evacuation plan in case the residents had to be relocated. E1 did not have a detailed evacuation plan in case of emergency. On 07/05/12 at 7:45 PM, portable air-conditioning units were delivered to the facility.

The residents were evacuated to the Island Lake Village Hall on 07/06/12 at 2:00 PM by order of Z1 related to extreme heat conditions and increased risk of fire related to overloaded electrical panels. Z1 explained, Z5 (Lieutenant with Island Lake Fire Department) agreed the building was unsafe and the residents had to be moved.

On 07/18/12 at 9:00 AM, Z1 (Island Lake Chief of Police) stated, "[On Friday 07/06/12,] I walked in the facility between 11:30 AM and 12:45 PM to follow up from a call I received the night before. The facility had come up with a resolution to the heat. They had portable air-conditioning units running since 12:00-1:00 AM. The cooling units were not effectively cooling the building. When I walked in form outside it was extremely hot...I asked to see the electrical boxes. I placed my hand on the boxes and they were hot to touch. The panels were dangerously hot. The fire department was called and the fire department used a thermal imager to read the temperature of the breaker panel. The panel read 150 degrees F."

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(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
F9999	Continued From page 28	F9999		

On 07/18/12 at 10:25 AM, Z3 (Emergency Management Agency (EMA) Coordinator for Island Lake) stated, "The only staff at the evacuation site was myself and my grandchildren because of the lack of notice. I could have notified EMA volunteers and village staff had I been notified sooner. I am not aware of any long-term evacuation plan. We could provide a place for a maximum of twenty-four hours."

On 07/19/12 at 10:50 AM, Z4 (Lake County EMA Coordinator) stated, "It required an emergency evacuation which could have resulted in serious harm to the residents in the facility. The first responders had to develop an evacuation plan. The evacuation [of residents] was delayed because the facility did not have a plan in place. It put the residents at unnecessary risk and could lead to serious harm or death."

On 07/18/12 at 2:30 PM, E1 (Administrator) stated, "I do not have a copy of any agreements for evacuation with another facility. I didn't know the resources that were available.

On 07/18/12 at 12:40 PM, E2 (Director of Nursing) stated, "We did not have a means to cool the building. No, I did not know there were agencies available to call. The facility did not contact any [Emergency Support] agencies prior to temperatures reaching unsafe levels. I have not received any diaster or emergency properness training [by the facility]. I am unaware of any nursing staff training related to disaster or emergency preparedrness. I am unaware of any arrangements with outside agencies to assist with transport or overnight shelter. I did not know IDPH had to be notified if temperatures exceed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E242	A. BUILDING _____ B. WING _____	07/25/2012

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F9999	Continued From page 29 81 degrees Fahrenheit." On 07/19/12 between 2:30 PM and 4:00 PM, all employees (E4-E8) (all CNAs) and E3-E4 (RN)) interviewed stated the facility had not provided any formal training on disaster preparedness or provided information on the evacuate residents from the facility in the event of an emergency. (B)	F9999		