STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
COVENTRY LIVING CENTER
STREET ADDRESS, CITY, STATE, ZIP CODE
612 WEST ST MARY’S STREET
STERLING, IL  61081

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SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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Statement of Licensure Violations:

300.1210b) 300.3220f) 300.3240a)

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.

Section 300.3220 Medical Care
f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility’s director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide specialized services by not administering prescribed medications to manage...

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

STATE FORM 6899 0FK911
If continuation sheet 1 of 7
Continued From page 1

A resident's behavior due to mental illness. This applies to 1 of 3 residents (R1) reviewed for behavior management in the sample of 6.

The findings include:

R1's Physician Progress Note of 4/4/14 shows diagnoses to include Bipolar Disorder, Psychosis NOS (Not otherwise specified), and Chronic Anxiety.

R1's admission assessment dated 3/26/14 at 1530 (3:30 PM) shows "No recent changes in mental status...Orientation x 3...mood - cheerful, pleasant...changes in mood - None..."

R1's Nurse Note dated 3/26/14 at 8:00 PM shows "pt assisted to restroom at 1130 pm and demanded to sit on the floor because she thought the staff member assisting her was going have a baby and she needed to be on the floor in order to catch it. Pt. was told that there was no baby to be delivered and she then pushed the staff member and said "you stupid girl move so I can catch your bloody baby". She then sat down on the floor...pt has been crying at times this shift and when asked what is wrong she will talk about family members passing away. She stated that her husband and daughter are both deceased after they both came to visit her this shift and she also spoke to them both on the phone..."

R1's 3/27/14 at 8:30 AM nursing assessment shows "disoriented, confused, short term memory loss...repetitive behavior, disruptive behavior, Became more agitated as the day progressed and became verbally and physically aggressive with a CNA (Certified Nurse Assistant)."

R1's Narrative Nursing Note dated 3/27/14...
**Continued From page 2**

documents "spilled a cup of coffee on her lap at supper time..."

R1's 3/28/14 Narrative Nursing Noted dated 3/28/14 at 5:49 AM shows "Pt. combative with staff and speaking with an elevated voice. Pt. made frequent attempts to get out of w/c (wheelchair) unassisted and was oriented to person only. Pt spoke about seeing bugs crawling out of the walls and mice on the floor. Doctor contacted regarding behaviors and new orders for PRN Ativan and and Haldol were received. ..."

R1's 3/28/14 Narrative Note at 9:00 AM shows "Resident spilled a cup of coffee on her lap. Appeared to be intentional and attention-seeking behavior..."

R1’s 4/1/14 at 2:26 AM nurse note shows "Pt out and about this tour. Wanders around the facility, freq looking out doors and windows. Pt states that she had 4 doctors at her previous facility and that they all fought over what was wrong with her. Pt tells that the doctors then went down into the basement and had rockets they were fighting over as well, in the end the doctors were peeing on each other with rocket fuel...pt dials her phone repeatedly throughout this tour, says she is calling her husband to see if his "side treat' is there or not...Attempted several times to explain to pt that it is midnight and he will not be here for several hours (husband). pt states that the new time system here is totally confusing and with the way we figure out time she will never catch on. She is pleasant, occ tearful when she talks about her husband...

R1's 4/3/14 at 10:42 PM documentation shows "945 PM, res. had woke up from a little nap and..."
### Statement of Deficiencies and Plan of Correction

- **Provider/Supplier/CLIA Identification Number:** IL6011373
- **Date Survey Completed:** 04/15/2014

### Name of Provider or Supplier

**Coventry Living Center**

612 West St Mary's Street
Sterling, IL 61081

### Summary Statement of Deficiencies

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Thought she was in different facility. This made her anxious and she was stating that she had to get back to were she was or her daughter would have locked up at "sing sing". Then she was asking to see the baby...

R1's 4/3/14 Nurse note shows "Pt exited unit from the north hall door. Alarm sounded and this writer responded immediately. Pt is walking in the grass with her winter coat and hat on, using a cane...CNA requested please call for assistance in getting pt back in. Pt walked around the building and through the front parking lot. Then began to walk toward the building...pt turned towards the street and walked through the ditch and onto road...pt crossed the road and then began walking in the ditch...veering into the corn field several times...patient states she is going to [law office] because she needs a lawyer...425 am Police officer accompanied pt up the driveway and into the facility...

R1's 4/5/14 Nurse note shows "heard screams from the hallway. Returned to see this pt striking [visitor] on her head several times with a cane. Moved pt back inter her room and removed the cane. Pt states there are dead people all over. And she has to get them out wit the cane. Placed call to 911 to report violent pt. Pt remained in her room for several minutes then began walking toward the doors to main hallway. Stood in front of pt and told her that she could not go out at this time, pt then punched this writer in the mouth, causing my lip to bleed and attempted hit me in the head with a remote that she was holding. prevented being struck by grabbing her swinging arm and then removed the remote from her other hand...She told the officers about the dead people and that this writer had given her shot with a 4 (inch) needle. And that is why she punched
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
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**NAME OF PROVIDER OR SUPPLIER**

COVENTRY LIVING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

612 WEST ST MARY'S STREET
STERLING, IL 61081

**SUMMARY STATEMENT OF DEFICIENCIES**

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me. This pt has recd no meds from the today...Police requested ambulance assist, pt enroute to [medical center].

R1's 4/5/14 at 9:15 AM Nurse noted shows "Addendum to previous note: When placing pt back on her bed after striking the girl in the hallway pt laid down on her bed and began swinging fists at staff and kicked this writer in the head..."

R1's physician progress note dated 4/4/14 shows "pt got out of facility in the middle of the night in the rain and staff couldn't get her back in and required the assistance of police. Alternate accommodations being sought for her".

R1's physician progress note dated 3/28/14 shows "Bipolar Disorder/Psychosis NOS (not otherwise specified) /Chronic Anxiety...Start Tegretol and Risperdal...continue PRN Haldol and Ativan"

R1's facility "Medication Incident/Error Report" dated 4/2/14 shows "Orders for Risperdal and Tegretol written on 3/28/14 were not transcribed to the MAR's and not given until today (4/2/14)."

R1's Medication Record shows the first dose of Tegretol 200 mg was not given until 4/2/14. This record shows the first dose of Risperdal 0.5 mg was not given until 4/2/14 (5 days after the order was written).

On 4/10/14 at 10:45 AM, E11 (Licensed Practical Nurse- LPN) said she took the orders for R1’s Risperdal and Tegretol out of the chart and faxed them to the pharmacy on 3/28/14. E11 said the chart then went back to the physician so he could talk to the family before the orders got put on the MAR. E11 said she did not see the chart when it
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>Continued From page 5 came back from the physician. E11 said the order was missed and did not get processed until 4/2/14. E11 said after the order is faxed to pharmacy it should be transcribed onto the MAR, and also put on a clipboard at the nurse's station so the nurses are aware of any new resident orders. On 4/10/14 at 9:00 AM, E3 (Regional Consultant) said the Tegretol and Risperdal were not transcribed from the physician's order sheet to the MAR (Medication Administration Record). E3 said &quot;it was our fault the meds were not given, not the pharmacy's&quot;. E3 said the order was written on 3/28/14, and the first dose was not given until 4/2/14. E3 said the meds were delivered on 3/29/14 to the facility and were placed in the bottom drawer of the med cart. E3 said when the nurse did not see the medications on the R1's MAR, she should have checked the physician's orders to clarify if the medications were ordered, or called pharmacy to see why they were delivered. On 4/10/14 at 4:45 AM, E1 (Administrator) said R1 was sent to the Emergency Room on 4/5/14 because she was a danger to other residents, and to herself. E1 said the facility was unable to manage R1's behaviors and had already told the family if any other incidents occurred, R1 would have to be transferred to another facility. On 4/10/14 at 9:00 AM, E3 (Regional Consultant) said R1 was sent to the Emergency Department for evaluation because she &quot;was a safety hazard to herself, the other residents, and staff members&quot;. On 4/10/14 at 11:30 AM, E2 (Director of Nursing) said at the time of R1's discharge to the hospital...</td>
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Illinois Department of Public Health

STATE FORM
### Statement of Deficiencies and Plan of Correction

**State:** Illinois

- **Provider/Supplier/CLIA Identification Number:** IL6011373
- **Multiple Construction: A. Building:**
- **Multiple Construction: B. Wing:**
- **Date Survey Completed:** 04/15/2014

**Name of Provider or Supplier:** Coventry Living Center

**Street Address, City, State, Zip Code:** 612 West St Mary’s Street, Sterling, IL 61081

**Summarized Statement of Deficiencies**

**S9999** Continued From page 6

(4/5/14), R1 "was a danger to herself, had attacked staff members, punched a nurse in the face, and hurt a visitor". E2 said R1 had dangerous behaviors that worsened during night hours, and seemed to become more severe since admission to the facility.

On 4/15/14 at 12:00 PM, Z1 (Physician) said the Risperdal and Tegretol were ordered to treat R1’s Bipolar Disorder, and Anxiety Disorder. Z1 said Risperdal has a quick onset and the medication could start helping R1’s behaviors the same day it was started. Z1 said the facility notified him R1’s medications was ordered on 3/28/14 but it was not started until 4/2/14 due to a nursing error.

( B)