

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145615	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2014
NAME OF PROVIDER OR SUPPLIER COVENTRY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 612 WEST ST MARY'S STREET STERLING, IL 61081		
(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 000	INITIAL COMMENTS	F 000			
F 246 SS=D	<p>Complaint # 1414457 IL#00072437</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide necessary equipment to accommodate a resident 's physical limitations. This applies to 1 resident reviewed for equipment needs (R1) in the sample of 5. The findings include: R1 ' s Physician 's Order Sheet-POS shows that R1 has diagnoses that include Left Leg Total Knee Replacement. R1 ' s Minimum Data Set-MDS shows that R1 is cognitively intact and requires 2 staff assist for ambulation and transfers. R1's admission notes show that R1 was admitted on October 5, 2014. (Sunday) On 10/14/14 at 10:55 AM, R1 said, I arrived here on a Sunday around 10:30 AM. I needed to go to the restroom. There was no walker in the room. I was told by a staff that they were not expecting me. Yet it 's obvious they knew because it was the facility ' s van that came and picked me up</p>	F 246			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145615	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2014
NAME OF PROVIDER OR SUPPLIER COVENTRY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 612 WEST ST MARY'S STREET STERLING, IL 61081		
(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 246	Continued From page 1 from the hospital. Nothing was ready for me. They could not find a walker and they could not find a commode. " I felt that they did not want to look for it. " These are my basic needs, I just had surgery. I had a long cast on my left leg, from my groin to my toes. I was on a non weight bearing status. " I need to use the bathroom, I was thinking, what if I go in my wheelchair? That would be so degrading! " I need my walker and I need a commode. To drag my newly operated left leg with a cast to use the restroom is unacceptable! I'm not supposed to put any weight on it. One of the staff said: " the therapy room is close on the weekend, so we cannot get what you need. " I wanted to go back to the hospital. At least they have what I need there. I had to call my son to bring my walker and my commode. After my son brought these things then they (facility) brought a walker and commode. The staff should know where to find the things a patient needs. What if I did not have a son to do these things for me? Someone dropped the ball. How would you feel if it was your loved one? At 11:25 AM, E5 said, I was R1's Certified Nursing Assistant-CNA that day. R1 got here around 10:30 in the morning, it was a Sunday. She needed a bedside commode. I did not know where to get a commode. I finally found one at the other side of the building. R1 needed a walker too. I found a walker in our supply room. I did not know she called her son. Her son brought this stuff around 11:15 AM. I was not fast enough. I ' m only one person. If I knew she needed the commode and the walker, I could have gotten that before she arrived in the facility. At 10:50 AM, E4- Assistant Director Nursing-ADON said that while the C.N.A. ' s were looking for the walker and the commode, R1 texted her son and the son brought the	F 246			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145615	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/15/2014
NAME OF PROVIDER OR SUPPLIER COVENTRY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 612 WEST ST MARY'S STREET STERLING, IL 61081		
(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 246	Continued From page 2 equipment by 11:30AM, the same time the staff found the equipment. At 10:25, E3 Admissions said, she thought R1 was coming on a Monday. E3 said she was notified by one of the nurses on Saturday, 10/4/14 that the hospital called to inform the facility that R1 is coming tomorrow. I made sure the van had a wheelchair for her when they picked her up from the hospital. At 10:35 AM, E2-Director of Nursing-DON said, R1 needed to be toileted right away as soon as she arrived. She needed a bedside commode and a walker. The son brought these things while R1 's C.N.A. was still looking. E2 said we normally have what they need. E2 also said, R1 was supposed to be a Monday admit. At 10:00 AM, E1-Administrator said, when a resident gets here, they have what they need. We have our own supply, we never rent. R1 was a Sunday admission and E3- (admission) was off. R1 's careplan dated through 10/7/14 under self care performance deficit shows, Limited Mobility: Interventions include- toilet use- bedside commode for elimination needs.	F 246			