STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145606	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Living - Windsor Park	110 Windsor Park Drive Carol Stream, IL 60188

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview, and record review, the facility failed to obtain physician orders for resident medications and for it to be at the bedside. The facility failed to complete self-administration of medication assessment. This applies to 8 of 8 residents (R8, R9, R17, R22, R45, R50, R120, R122) reviewed for medications in a sample of 24. The findings include: 1. On 4/16/24 at 10:20 AM, R50 had Nasacort Allergy 24 120 SPR nasal drops her on bedside table. R50 stated, The nurse didn't watch me use it. He just put it here and then walked out. I put two sprays in each of my nostrils. R50's POS (Physician Order Sheet) shows Nasacort 55 MCG (Micrograms) nasal spray aerosol (2 sprays) in each nostril BID (Twice a Day). There was no order for it to be at the bedside. R50's MDS (Minimum Data Set) dated 3/14/24 shows a BIMS (Brief Interview for Mental Status) score of 15, which means she is cognitively intact. Review of R50's medical record shows no self-administration of medication assessment or care plan was done. 2. On 4/16/24 at 10:41 AM, surveyor went to R8's room. She was not in her room. On her end table, inside a plastic bag, there was Klayesta 100,000 unit/gm (grams) powder (Nystatin Topical Powder). On 4/17/24 at 12:49 PM, surveyor went back to her room. The medication was still there. R8 stated, It's always in my room. The nurse hasn't been using it for days. I've put it on before, but I stopped putting it on myself. It's been a while since I last used it. R8's POS shows Klayesta 100,000 units/gram topical powder by shift starting 3/26/24. Indication: Redness on abdominal folds and both inguinal areas. There was no order for it to be at the bedside. R8's MDS dated [DATE] shows a BIMS score of 13, which means she is cognitively intact. Review of R8's medical record shows no self-administration of medication assessment or care plan was done. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2024
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 4/16/24 at 11:10 AM, R122 had Levalbuterol Tartrate inhaler on her bedside table. R122 stated, It's always kept here. No one taught me how to do it. I do it by myself. On 4/17/24 at 10:02 AM and on 4/18/24 at 9:55 AM, the inhaler was still on her bedside table. R122's POS shows an order for Albuterol Sulfate HFA 90 MCG (Micrograms)/actuation aerosol inhaler PRN (As Needed) every 4 hours. R122 did not have an order for the Levalbuterol Tartrate inhaler. R122's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact. Review of R122's medical record shows no self-administration of medication assessment or care plan was done. 4. On 4/16/24 at 12:48 PM, R120 was not in her room. There was Refresh Tears Lubricant eye drops on her bedside table. R120's POS does not show an order for the eyedrops. R120's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact. Review of 120's medical record shows no self-administration of medication assessment or care plan was done. On 4/17/24 at 8:14 AM, V3 (LPN-Licensed Practical Nurse) stated, You need an order from the doctor to have medication at the bedside. The patient has to be alert and needs to be assessed. It's very rare that we have patients that have medications here at the bedside. On 4/17/24 at 9:59 AM, V2 (DON-Director of Nursing) stated, No one self-administers medications as to my knowledge. If family brings in medications for the residents. They need to show the nurse. Then the nurse has to get an order from the doctor. You have to get an order for medications to be at the bedside from the doctor. The nurse has to do a self-administration of medication assessment which should be in the EMAR (Electronic Medication Administration Record). The resident has to do a return demo and there should also be a care plan. Facility's policy titled Self-Administration of Medications (February 2021) shows the following: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care pan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision making status. 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. 46380 5. R45 was admitted to facility on 3/15/2024. Diagnoses includes fractured left femur, type II diabetes mellitus, hypothyroidism, and hypertension. MDS (Minimum Data Sheet) dated 3/19/2024 documents that R45 has intact cognitive functions. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/16/2024 at 11:19 AM, R45 had an extra-large pill box on her bedside table which was in front of her. There were five medications on the compartment labeled Wednesday. She said it contained Vitamin D3, Magnesium, Probiotics. Milk [NAME] and CoQ10. Resident was unable to say the dose of each medication. She said her daughter prepares it and brings it to the facility every Wednesday. She said she self-administers the medications every morning. On 4/17/2024 at 9:42 AM, same pill box was noted on R45's bedside table. There were no medications noted in the pill box. She said she self-administered the medication after breakfast. She said her daughter will come this afternoon to give another week worth of medication. On 4/18/2024 at 9:02 AM, R45 had another pill box on her nightstand. The pill box had medications in all compartments. R45 said her daughter brought it in yesterday and she will take pills inside the Thursday compartment after breakfast. On 4/18/2024 at 8:36 AM, V2 (DON-Director of Nursing) said nobody in the facility has an order to self-administer medications. She said if medications are brought to the facility by family and were not labeled, they give it back to family. If it is a supplement the resident wants to take, they must inform the physician, obtain order, and administer it as ordered. She said there is an assessment the staff needs to complete for self-administration. If assessment shows the resident is capable, the nurse should obtain an order for self-administration, do a return demonstration, and make a care plan. On 4/18/2024 at 9:10 AM, V10 (RN-Registered Nurse) said she knew R45 had a pill box in her room filled with medication. She said she knew the daughter brought it in. She said she did not think to inform the physician about it. She said she did not think to complete the Self-Administration assessment or obtain order from physician. On 4/16/2024 at 3:30 PM, review of R45's POS (Physician Order Sheet) does not show orders for Vitamin D3, Magnesium, Probiotics. Milk [NAME] and CoQ10. There is no order for resident for resident to self-administer medication and for medication to stay at bedside. There was no assessment done for Medication Self-Administration. 44387 6. On 4/16/24 at 10:39 AM, there was a bottle of saline nasal spray on R9's bedside table. On 4/17/24 at 9:05 AM, the bottle saline nasal spray was still on R9's bedside table, there was also a bottle of Nystatin topical powder 100,000 units on R9's nightstand. R9 said Nystatin powder is used under her arms, and the nasal spray is hers, but it does not work. On 4/18/24, the bottle of saline nasal spray and Nystatin powder was still noted in R9's room. Review of R9's current Physician Order Sheet (POS), R9 has an order to apply Nystatin Powder, apply under bilateral breast. R9 did not have an order for saline nasal spray or to self-administer medications. R9 is not care planned to self-administer medications. 7. On 4/16/24 at 11:08 AM, there a bottle of Systane lubricating eye drops on a table in R17's room. On 4/17/24 at 9:22 AM, the bottle of Systane eye drops still noted on the table in R17's room. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R17's POS, R17 did not have an order for Systane eye drops or to self-administer medications. R17 is not care planned to self-administer medication. 39182 8) On 04/16/24 at 12:30 PM, observed the medication 'Serevent Diskus' on R22's bedside table. R22 stated, he takes it twice a day by inhalation and that no one supervises him do it. R22 stated that he did not receive any specific instructions on how to use it. On 4/18/24 at 9:00 AM, observed Serevent Diskus on R22's bedside table. V4 (ADON-Assistant Director of Nursing), witnessed the medication on the bedside table. R22's POS (Physician Order Sheet) for April 2024 showed ''Serevent Diskus 50 mcg/dose powder for inhalation two times daily'. R22's Progress Notes did not have any documentation or assessment regarding R22's capability to self-administer his medications. On 4/18/24 at 9:05 AM, V4 (ADON) stated, R22 is not supposed to have any medication at his bedside. On 4/18/24 at 10:10 AM, V2 (DON-Director of Nursing) stated, R22 do not have an order to keep any medication at his bedside and it should not have been left at his bedside.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 44387 Based on observation, interview and record review, the facility failed to provide ADLs (Activity of Daily Living) care to residents. This applies to 3 of 3 residents (R5, R6 and R9) reviewed for ADL care in a sample of 24. The findings include: 1. On 4/16/24 at 10:39 AM, R5 was observed resting in bed; R5 had several white hair on her chin. On 4/17/24 at 9:05 AM, R5 is in bed, still noted with facial hair on her chin. On 4/18/24 at 9:40 AM, R5 was in bed resting, facial hair still noted on her chin. R5's Minimum Data Set (MDS) of 3/30/24 shows that R5's cognition is moderately impaired and need partial/moderate assistance with personal hygiene. R5's current care plan shows that R5 has self-care deficit and needs existence assistance required with bathing, hygiene, dressing, and grooming. 2. On 4/16/24 at 10:49 AM, R6 was in bed resting; R6 had several gray, white hair on her chin. R6 MDS of 1/25/24 shows that R6's cognition is severely impaired and is dependent on staff for all personal hygiene. R6's current care plan shows that R6 has ADL deficit and requires extensive total assistance with most ADLs. 3. On 4/16/24 at 11:30 AM, R9 was observed sitting in wheelchair in dining room, R9 had several white facial hair on her chin. On 4/16/24 at 9:06 AM, facial hair still noted on her chin; R9 said she does not like her facial hair. On 4/18/24 at 9:34 AM, R9 was in her room in bed, R9 still noted with hair on her chin. R9's MDS of 2/16/24 shows that R9's cognition is intact and need substantial to maximal assistance with personal hygiene. R9's current care plan shows R9 has self-care deficit and needs extensive assistance with bathing, hygiene, dressing and grooming. On 4/17/24 at 10:03 AM, V9 (Certified Nurse Aide) said CNAs are responsible for ADL care which includes grooming, shaving, nail care and incontinent care. Grooming is done twice a week and as needed. On 4/18/24 at 8:37 AM, V2 (Director of Nursing/DON) said the CNAs are responsible for shaving, nail care and grooming. The facility's Activities of Daily Living (ADL), Support policy (revised March 2018) states that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 44387 Based on observation, interview and record review, the facility failed to ensure anti-contracture devices were applied as ordered. This applies to 2 of 2 residents (R5 and R6) reviewed for anti-contracture devices in a sample of 24. The findings include: 1. On 4/16/24 at 10:39 AM, R5 was in bed resting; R5's right had was noted in a fist position resting on her abdomen. On 4/17/24 at 9:05 AM R5's right hand noted in fist position, there was no splint on. On 4/18/24 at 9:40 AM, there was no splint on R5's right hand. R5's Electronic Medical Record (EMR) shows the following diagnoses of injury of right wrist, hand and finger, pain in right wrist, and right wrist drop. R5's Minimum Data Set (MDS) of 3/30/24 shows that R5's cognition is moderately impaired. R5's current Care Plan shows that R5 requires right wrist splint due to right wrist pain. 2. On 4/16/24 at 10:49 AM, R6 was observed resting in bed in her room. R6's right hand was noted in a fist position. At 12:15 PM, R6's right hand was still noted in a fist position, there was no splint. R6's EMR shows the following diagnoses of hemiplegia following cerebral infarction affecting right dominant side and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. R6's MDS of 1/25/24 shows that R6's cognition is severely impaired. R6's current Care Plan shows that R6 requires splint to her right hand due to contracture. On 4/18/24 at 10:43 AM, V11 (Restorative Nurse) said R5 has a brace for her right hand due to right wrist pain. V11 said R5 had a fall prior to being admitted to the facility, and she requires a brace to the right hand. V11 said the brace is to be applied during the day and off at night. V11 said R6 has a right hand splint for contractures to the right hand. V11 said the splint is applied during the day and off at night. V11 said the CNAs (Certified Nurse Aides) are responsible for applying the splints and brace. The facility's Resident Mobility and Range of Motion policy (revised July 2017) states that residents with limited mobility will receive appropriate services, equipment and assistance to maintain and improve mobility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 44387 Based on observation, interview and record review, the facility failed to properly position indwelling catheter bag/drainage bag during care. This applies to 1 of 1 resident (R5) reviewed for indwelling catheter in a sample of 24. The findings include: On 4/17/24 at 9:53 AM, V9 (Certified Nurse Aide) provided catheter care to R5. During the care, V9 placed R5's catheter drainage bag on the bed, cleaned the catheter tubing, and then lifted the catheter bag above bladder line to wipe the tubing with alcohol wipe. Back flow of urine was observed in the catheter tubing. On 4/18/24 at V2 (Director of Nursing/DON) said catheter bag should be placed below the bladder line so urine can flow with gravity. The facility's Catheter Care, Urinary policy (revised August 2022) states to position the drainage bag lower than the bladder at all times to prevent urine from flowing back to the urinary bladder.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39182 Based on Observation, Interview, and Record Review the facility failed to: perform hand hygiene, contain soiled linen and follow current standards of infection control during pressure ulcer dressing change. This applies to 3 of 3 (R51, R167 and R168) residents reviewed for infection control in a sample of 24. Findings include: 1) On 4/16/24 at 11:35 AM, observed R167 standing at his bedside leaning forward, holding onto his wheelchair handles, supported by V5 (CNA-Certified Nursing Assistant) on his right side and V8 (WCD-Wound Care Doctor) bent over trying to measure the wounds on either side of his gluteal folds. After measurement, V8 did not do hand hygiene or change his gloves, touched the door handle to open the door and left the room. V8 again came into the room and explained the status of the wound to R167. During the conversation, R167 sat on the wheelchair with his wound open and no clean field established. After V8 finished explaining, V8 and V5 helped R167 to stand up again. V7 (WCN-Wound Care Nurse) cleansed the wound with normal saline and placed the soiled gauze on R167's bed. V7 did not do hand hygiene or change her gloves. V7 applied sterile bordered gauze on the wound, held it with one hand and with the other hand took a sterile self-adhesive dressing. As V7 was applying the self-adhesive dressing on R167, it fell on the wheelchair. V7 picked it up and applied the same dressing on the wound. 2) On 4/16/24 at 12:35 PM, observed R51 was in right lateral position and V8 (WCD) was measuring the wound on R51's sacrum. Observed there was no clean field established on the bed near R51's wound. After the measurement, V8 (WCD) went around the bed to face R51 and explained the status of his wound to R51. As R51 was listening and talking to V8 (WCD), he turned slightly. Observed that R51's back including the open wound touched the bedsheet. Meanwhile, V7 (WCN-Wound Care Nurse) was standing near R51, observing the resident. After V8 (WCD) finished talking to R51, he removed his gloves, no hand hygiene done, touched the door handle to open the door of the room and left the resident's room. V7 (WCN) repositioned R51 onto his right lateral position, did not clean the wound, applied gauze and self-adhesive dressing on the wound. 3) On 4/17/24 at 11:07 AM, observed soiled linen on the floor in R168's room. V5 (CNA) stated, she was making R168's bed and threw the linen on the floor as she did not have a hamper or a plastic bag in hand. On 4/17/24 at 11:10 AM, V5 (CNA) and V6 (CNA) stated they were not supposed to throw soiled linen on the floor and that it should be contained in a plastic bag before transporting it to the soiled utility room, to prevent cross contamination. On 4/18/24 at 10:10 AM, V2 (DON-Director Of Nursing) stated, soiled linen must not be thrown on the floor. V2 stated, soiled linen must be placed directly into a covered hamper. V2 (DON) stated, After touching the wound, soiled gloved must be discarded and hand hygiene must be done before touching any other surface. V2 stated, wound care nurse did not follow infection control principles while doing the dressing for R167 and R51. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy on 'Laundry and Linen' dated 01/2014 showed, Bagging and Handling Soiled Linen. 1. All soiled linen must be placed directly into a covered laundry hamper which can contain the moisture . Facility policy on 'Wound Care' dated 10/2010 showed, . Steps in Procedure. 3.Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites.4. Put on exam gloves . and remove dressing. 5. Pull glove . and discard into appropriate receptacle. Wash and dry hands thoroughly. 10. wear sterile gloves when physically touching the wound.