STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012991	A. BUILDING: _____ B. WING _____	C 12/21/2017

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VILLA HEALTH CARE EAST	100 MARIAN PARKWAY PO BOX 109 SHERMAN, IL 62684

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S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 1 Violation Complaint Investigations 1747212/IL98752 1747352/IL98905 300.610a) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

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S9999	Continued From page 2 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to identify, monitor and treat a significant condition change for one of 3 residents (R3) reviewed for significant condition change in a sample of 8. This failure resulted in delay in treatment for R3 who presented to the emergency room on 11/26/17 in critical condition and expired on 11/30/17 from Sepsis and Pneumonia. Finding includes:	S9999		

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1. The Minimum Data Set (MDS) dated 10/16/17 documented R3 as an 80 year old male admitted to the facility on 6/9/17 with diagnoses of Nontraumatic Intracerebral hemorrhage, Dysphagia, Hemiplegia/hemiparesis and Dementia in part. The MDS documented R3 had severe cognitive deficits with a Brief Interview of Mental Status score of 3. The MDS documents R3 required extensive assist of one to two staff members for all activities of daily care.

Progress Note dated 11/24/2017 at 6:15 PM entitled "Health Status Note" entered by V4, Licensed Practical Nurse (LPN), documented "Pt (Patient) noted to be lethargic during evening meal time. Able to arouse with voice et (and) touch. Alert to wife. vitals WNL (Within Normal Limits). No intake of evening meal. Able to take in honey thick liquids offered by wife without difficulty. No changes noted with urination or bowel movements. Remains incontinent of both. Wife does not want sent to the hospital for testing. Will alert Dr (V14) if pt declines. Wife remains at bedside. Will cont (continue) to monitor."

The next entry into the progress notes was on 11/26/2017 at 9:04 AM written by V5, LPN, as a "Health Status Note." The Note documented "POA (V8, Power of Attorney) here this a.m. and informed writer that she was here to take res (resident) to ER (emergency room). Writer inquired why she felt he needed to go to ER, res was up and in Dining room awaiting his breakfast. POA states 'She has a gut feeling that something was off.' Writer informed her the MD would need to be notified and updated on why res needed to go and an order would need to be given. POA states 'regardless if MD (Medical Director) gives an order or not he is going even if she has to call

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911.' MD paged at this time to inform of POA wishes." There was no documentation in R3's medical record the nursing staff monitored or assessed R3 for further decline after he was identified as being lethargic on 11/24/17 at 6:15 PM.

On 11/26/2017 at 9:10 AM, V5 documented as a "Health Status Note", "Res removed from Dining Room at this time and taken to room to assess, d/t (due to) POA concerns. Res a/o (alert/oriented) to self at this time and is able to answer simple questions. Res voices no discomforts at this time but is agitated at writers questions, V/S (Vital signs) stable, 98.8, 88, 16, 144/72. Res remains incontinent of B&B (bowel and bladder)." At 9:34 AM, V5 documented, "Return call from (V13, MD) on call for (V14, MD) updated on res and POA wishes to send res to ER for eval (evaluation), MD gave order to send res to ER."

R3's Progress Noted, dated 11/26/17 at 10:21 AM, documented R3 was transferred to the emergency room.

Emergency Department (ED) Notes dated 11/26/17 documented "The patient presents with lethargy, AMS (Altered Mental Status), so have concerns for UTI (urinary tract infection), BP (blood pressure) low on arrival 89/57" and "has decreased intake last 2 weeks, decreased urine output none today with catheter, euthermic, LLL (left lower lobe) crackles." The final report documented "wife at bedside reports over the past 2 weeks, patient has had progressive increase in general weakness and fatigue. Over the last 2 days, he has had increasing altered mental status and decreased activity. Wife reports he did not know who she was which is

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new for him. Also not knowing where he is at. Wife reports he has not been talking as much today and has appeared more fatigued." The note also documented "appetite has been decreased. Has not been eating or drinking much over the past few days."

The Physical Examination of the ED report documented "Lethargic, Moderate distress," "dry mucus membranes," and "was hypotensive and tachycardic upon arrival."

The Hospital History/Physical dated 11/26/17 documented "Patient is critically ill with vital organ impairment, with high probability of life threatening complications."

The Discharge Summary dated 11/27/17 documented in the emergency room, R3 "Was found to be in septic shock with lactic acidosis, acute kidney injury, hyperkalemia and right-sided pneumonia" with the family opting for Comfort care only. The Summary documented R3 was discharged to Hospice services.

The Death Certificate documents R3 expired on 11/30/17 with cause of death listed as Septic Shock and Pneumonia.

On 12/14/17 at 9:28 AM, V4 LPN stated she documented R3 was lethargic and did not eat any of his supper meal. V4 stated R3's wife, V8, did not want him sent to the emergency room that night but was concerned that he wasn't himself. V4 stated R3 did have periods of lethargy but his vital signs were stable. V4 stated she passed on her concerns to the night nurse but couldn't remember who that was. V4 stated she documented she would inform R3's physician but did not.

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On 12/14/17 at 10:55 AM, V6 LPN stated she worked from 8:00 PM on 11/24/17 to 6:00 AM on 11/25/17 but didn't remember receiving a report that R3 was lethargic. V6 stated she did not do any charting on R3 that evening. V6 stated that when she saw him, he was in his room describing him as "normal, responsive" with no complaints. V6 stated she wouldn't have charted on him as he was not on the "hot rack" to chart on. V6 also stated the CNA's (Certified Nurse Aides) didn't report anything unusual for him that night.

On 12/14/17 at 10:34:00 AM, V9 CNA stated she took care of R3 during day shift on 11/25/17. V9 stated R3 didn't respond normally that day, and "had a color about him." V9 stated he was a little more lethargic than what he normally was and ate/drank very little. V9 stated she did not do any vitals on R3 and that she reported her concerns to V5, LPN that day.

On 12/14/17 at 9:20 AM, V5 stated she didn't receiving any concerns regarding R3 on 11/25/17 and didn't report/record anything. V5 stated she was working the morning of 11/26/17 when R3's wife/POA (V8) came in and wanted to send him to the emergency room. V5 stated the wife told her she had a feeling something was not right with him and insisted they send him. V5 stated she did not note anything unusual for R3 that day and reiterated that he was up and in the dining room when his wife came in.

On 12/14/17 at 11:00 AM, V10 LPN stated R3 had no episodes the evening on 11/25/17 and that they usually put residents on the "hot rack" if they have concerns. V10 stated V5 had no concerns during report but did say R3's wife did not want him sent to the hospital. V10 stated R3

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S9999	Continued From page 7 had no issues that night to chart on. On 12/13/17 at 9:45 AM, V8, R3's wife/POA stated she had come in on 11/24/17 and found the room window open to the outside and the room was really cold. V8 stated she understood the window had been open since R3's roommate expired the evening before. V8 stated R3 had been declining for a couple weeks with increased lethargy, fatigue, and that she told the nurses of her concerns. V8 stated on 11/25/17, she came in at suppertime and R3 ate and drank very little. V8 stated she discussed her concerns with the nurse but wanted to wait until the morning to see how he was to make a decision then to send him to the emergency room. V8 stated she came in early on 11/26/17 and knew he was very ill. V8 stated the doctors stated he was critically ill and they put him in Hospice where he expired a few days later with sepsis and pneumonia. On 12/14/17 at 11:26 AM, V3 Assistant Director of Nurses (ADON) stated R3 was "perfectly normal" on 11/25 and 11/26/17 stating that sometimes he sat with his eyes shut and wouldn't respond when spoken to. V3 stated the facility uses a Hot Rack for residents who exhibit a condition change or are on an antibiotic which would trigger the nurses to chart on them. 24 hour report sheets provided on 12/14/17 by V3 document on 11/24/17 "0k for 3rd shift, "episode of lethargy 0 (no) dr (doctor) or hospital" for 1st shift and nothing documented for the 2nd shift. For 11/25/17, R3's accucheck is recorded as 165, with "ok" written for all three shifts. The 24 report sheet for 11/26/17 documents "ok" for 3rd shift, and that R3 was sent to the emergency room per POA request for 1st shift.	S9999		

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S9999	Continued From page 8 Meal intake records dated 11/20/17 and 11/21/17 document R3 eating 26-50% of breakfast and lunch with 76-100% recorded for supper. Meal Intake records dated 11/23/17 document R3 ate 51-75% for breakfast and supper with 76-100% documented for supper. For 11/24/17, R3 was recorded as eating 0-25% breakfast and lunch with no meal recorded for supper. On 11/25/17, the meal intake record documents R3 ate 26-50% breakfast and lunch with 0-25% recorded for supper. The CNA intake record for November 2017 document poor intake for the majority of the month. Dietary Progress note dated 11/15/17 documents R3 to have a 5% weight loss of 180 pounds 11/5/17 from 191.5 on 10/6/17 and a 10% loss since admission 6/11/17 of 201 pounds. The facility's policy/procedure entitled "Condition Change Documentation" dated 9/28/09 documented the purpose as being "to maintain a medical record which is reflective of documentation of the care provided to residents to include, but not limited, nursing assessment and notifications related to the change of a resident's condition." The Procedure documented nursing will assess the resident's complaints and complete a nursing assessment of the resident, document the complaints and nursing assessment into the clinical record, notify the physician of condition change, report to oncoming shift and implement the "hot rack" OR "condition change flowsheet" charting for each shifts use to monitor the resident's health status, Continue charting on the resident's condition change until the resident is free of clinical abnormals or symptoms free for three consecutive shifts (24 hours.) Under Note, the policy documented "Resident's presenting with condition change may have additional symptoms present thru the course of monitoring, notify the	S9999		

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S9999	Continued From page 9 physician of new or worsening symptoms." (A)	S9999		