Illinois Department of Public Health

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 _____	07/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA HEALTH CARE EAST	100 MARIAN PARKWAY PO BOX 109 SHERMAN, IL 62684

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 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 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.	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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S9999	Continued From page 1 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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 observation, interview and record review, the facility failed to ensure residents environment remains free of accident hazards by allowing residents with oxygen in the beauty shop near flammable hair chemicals and hair dryers. This has the potential to affect all of the 87 residents living in the facility.	S9999		

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S9999	Continued From page 2 Findings include: 1. Facility Policy and Procedure of 7/2009 for BEAUTY SHOP OXYGEN USE GUIDANCE documents, "Safety of resident(s) and beautician during provision of hair care. Oxygen when in use in a resident's room from any of the three common types of oxygen systems can create an oxygen-enriched atmosphere. In an oxygen-enriched atmosphere, materials that are combustible and flammable in air ignite more easily and burn more vigorously. Examples of these types of materials that may be found on or near residents in health care facilities can include hair oils, oil-based lubricants, skin lotions, facial tissues, clothing, bed linens, acetones, and some plastics. Items in a typical resident area can create a source of ignition if introduced into an oxygen-enriched atmosphere. These items can include hair dryers. For this reason, oxygen will not be administered in the beauty shop of this facility." On 7/9/14 at 10:05AM, R6 was observed in the beauty shop sitting in her wheel chair under the hooded hair dryer with a tank of oxygen on the back of the wheel chair and receiving Oxygen by nasal cannula. R12 was also in the beauty shop and no staff was in the attendance. At 10:07AM, E1, Administrator, was informed of the concern and removed R6 immediately from the beauty shop. E15, Beautician, was observed to bring hair spray out of beauty shop and to use on R6's hair once R6 was taken from the beauty shop. On 7/9/14 at 11:15AM, E17, CNA (Certified Nurse Aide) stated she did not know if staff takes off R6's oxygen when she gets her hair done. At that time, E18, CNA, stated to E17 that E1 needed to talk to E17 to discuss oxygen.	S9999		

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S9999	Continued From page 3 On 7/9/14 at 11:20AM, E15, Beautician, stated she had just been inserviced that no residents with oxygen were allowed in the beauty shop. E15 stated she had been unaware of dangers of residents with oxygen being in the beauty shop until E1 talked to her. E15 stated she has hair spray, hair dye, perm solution and other hair products that she keeps in the beauty shop at all times. E15 stated that E1 had just finished putting a sign on the door that no oxygen is allowed in the beauty shop. On 7/10/14 at 11:30AM, E16, LPN (Licensed Practical Nurse) stated she had been unaware of the risks of having oxygen in the beauty shop. 2. The Resident Census and Conditions of Residents, CMS 672, dated 7/8/14 documents that the facility has 87 residents living in the facility. (A) 300.610a) 300.1210b) 300.1220b)2) 300.1810h) 300.2040b) 300.2040d) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and	S9999		

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S9999	Continued From page 4 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 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status,	S9999		

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S9999	Continued From page 5 discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.1810 Resident Record Requirements h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. Section 300.2040 Diet Orders b) Physicians shall write a diet order, in the medical record, for each resident indicating whether the resident is to have a general or a therapeutic diet. The diet shall be served as ordered. d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the 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.	S9999		

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S9999	Continued From page 6	S9999		

These Regulations were not met as evidenced by:

Based on interview, observation and record review, the facility failed to ensure enteral feedings were provided as ordered to maintain and/or prevent weight loss for 1 of 1 residents (R5) reviewed with tube feedings in a sample of 18. This failure resulted in R5 having a 7.8% weight loss in 90 days

Findings include:

1. The Minimum Data Set (MDS) dated 5/28/14 identifies R5 as having cognitive impairment and requiring extensive assist of one staff for eating. The July 2014 Physician's Order Sheet (POS) identifies R5 to have a Percutaneous endoscope gastrostomy, (PEG) tube for nutritional support with the feedings at 75cc/hr 7am - 7pm per pump until 7/8/14 when the amount was increased to 90cc/hr for weight loss. The POS also documents R5 gets a "pleasure feeding per resident request", honey consistency liquids. The care plan dated 4/26/14 and revised on 5/28/14 identifies that R5 has swallowing problems and will maintain adequate nutritional support and hydration. Interventions include monitoring caloric intake, estimate needs, make recommendations for changes to tube feeding as needed, weekly weights and "Do not give me a tray, provide one food at a time for me. Staff to sit next to me while I am eating" in part.

Weights recorded for May 2014 was 145.2 pounds and June 2014 138.5 pounds. There are

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S9999	Continued From page 7 no weekly weights as indicated in the care plan revised 6/12/14. The Registered Dietician's (RD) E20 note dated 5/5/14 and 6/9/24 identifies the 75cc/hr tube feeding and po (by mouth) as meeting his needs with no recommendations made on 6/9/14 even though his weight went from 145.2 to 138.5 or a 4.7% weight loss. According to the RDs Note dated 7/7/14, R5's weight for July 2014 was 133.2 pounds showing a weight loss of 7.8% in 90 days and 8.3% in 180 days. E20 recommended for R5's tube feeding amount to be increased to 90cc/hr. There is no indication E20, reviewed and/or monitored R5's intake records to ensure he was receiving the correct amount of feeding as ordered. The last E24 Dietary Manager, (DM) documented on 5/28/14 R5's oral intake was 26-75% of his meal intakes. Laboratory Reports (labs) dated 9/9/13 show a low Albumin 3.0 (Normal 3.5-5.5) and a Total Protein of 6.5 (normal 6-8.3). Most recent labs dated 4/11/14 have Total Protein 6.6, Albumin 3.1 (L) and BUN 38 (normal 7-25) and Creatinine 1.1 (normal 0.6 - 1.3). Intake records for May, June and July 2014 show incomplete totals for each shifts with no total amounts recorded to ensure that R5 was receiving 900cc/12hr ordered. Amounts of feeding instilled and documented often calculate to less than the 900cc. Examples include 800cc - 7/8/14, 803cc - 7/7, 354cc - 7/6, 859cc - 7/5, 7/4 - 81cc, 7/3 - 875cc, 7/2 - 780cc, and 7/1 - 853cc. In June 2014, numerous amounts of feedings were under 900cc including 6/25/14 - 731cc, 6/22 - 794cc, 6/19 - 645cc, 6/18 - 728cc, 7/17 - 116cc, 6/14 - 124cc, 6/12 - 74cc, and on 6/16/14, no intake was recorded except a statement "off when I arrived" for the 6am time.	S9999		

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S9999	Continued From page 8 May 2014 also show numerous incomplete days. This documentation shows a pattern of not monitoring R5's enteral intake to ensure adequate feeding amounts as ordered and according to his care plan and facility policy. The tube feeding amount ordered per shift should be as followed: 6am-2pm shift - 75cc, 2pm-10pm - 225cc, 10pm-6am - 600cc for a total of 900cc. On 7/8/14 at 12:15pm, R5 was served his tray of food. He had potatoes and gravy, ground meat, puree vegetables, and a pureed dessert served in a divided plate. No staff stayed with him after the plate was delivered. He took a few bites, rolled back and forth from the table and tasted the all the food items. He ate no dessert. R5 was observed also at breakfast at 8:20am on 7/9/14 and noted to have no staff attention after his divided plate was delivered and no cueing/encouragement to eat more. He was observed again to pick at his food and ate only bites of his eggs, cream of wheat and sausage with none of his milk or red drink. On 7/11/14 at 9am, meal intake records were reviewed. On 7/8/14, the facility did not document R5's intake at the noon meal at all. R5 ate less than 25% of his porkchop, potatoes and vegetables, none of his milk or lemonade, a bite of dessert and 75% of a small glass of water. On 7/9/14 at the breakfast meal, the facility documented R5's intake as 100%. At 8am on 7/9/14, R5 ate only bites of his yogurt, a bite of egg, a smear of the sausage, 25% of his cream of wheat, none of his red drink or milk and only 75% of his water. He rolled himself away from the table with no staff intervention. On 7/9/14 at the noon meal, the facility documented R5 ate 51-75%.	S9999		

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S9999	Continued From page 9 The nurses notes dated 7/8/14 document that the RD's recommendation was ordered by the physician to increase R5's tube feeding to 90cc/hr from 7pm to 7am. A new note written by E24 dated 7/10/14, documents R5 to be on pleasure feedings, "appetite fluctuates from meal to meal" with both 26-75% and <25% circled, indicating a decreased oral intake. On 7/10/14 at 10:30am, E19 Corporate Nurse and E2, Director of Nursing (DON) acknowledged the intake records were incomplete with no totals recorded or monitored for R5's tube feeding. E2 stated the intake record's format is for three shifts but the nurses work 12 hour shifts and that could cause some problem in recording the amount. Both were also aware the amounts recorded were less than the 900cc ordered on the majority of the days reviewed. E19 stated R5 was scheduled to see the physician Both stated that there may be something going on with him that is causing the weight loss and the physician was to see him later that day. On 7/10/14 at 1:52pm, E19 confirmed that no weekly weights had been done. According to the Harris/Benedict Formula, when R5 weighed 145.2 pounds, he required 1980 calories/day to maintain weight. The Jevity 1.2 at 75cc for 12 hours supplies only 1080 calories leaving 900 calories to be taken by mouth. On 7/10/14 at 2:50pm, E20 stated she reviews the po (Oral) intake records because they are on the computer but she was not aware the nurses documented feeding intake anywhere. E20 stated she looks at his total needs being met with what he eats orally and his tube feeding.	S9999		

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S9999	Continued From page 10 However, she did acknowledge that his feedings were pleasure. On 7/11/14, E20 stated she recalculated his needs to be 1650 calories with 66 gm of protein, 1650cc fluids daily. The tube feeding calculated at 90cc/hr for 12 hours equals 1296 calories with 60gm of protein and total fluids provided with the tube feeding is 1592cc. E20 stated she did not watch him eat on 7/7/14 when she was in the facility doing his assessment. When asked about calculating fluids based on 30cc/kg which totals 1812cc not 1650, E20 stated she uses 25-30/cc per kilogram based on labs, skin condition and what the resident eats or drinks. The facility's policy entitled "Enteral/Tube feeding policy" documents that all residents receive basic nutrition while in the facility and the objective is to maintain a consistent plan of care for residents who require tube feedings due to the inability to eat enough to sustain life. Under Documentation requirements, it documents "Administration will be documented on the medication administration record by licensed staff and "the amount of the feeding and water will be accurately recorded for each shift of administration of the feeding by licensed staff." (B)	S9999		

F323: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.

Based on observation, interview and record review the facility failed to ensure resident's environment remains free of accident hazards by allowing resident with oxygen in the beauty shop near flammable hair chemicals and hair dryers.

Corrective action which will be accomplished for that resident found to have been affected by the deficient practice. R6 was removed immediately from the beauty shop. R12 was not on oxygen. The beautician received a direct reeducation on 7/9/14. All staff in-service was completed on 7/9/14 on the risk of oxygen in the beauty shop. A sign was placed at the door to not bring oxygen into the beauty shop. The policy and procedures for beauty shop oxygen was reviewed with the IDT team. An audit tool was put into place to check the beauty shop for anyone on oxygen. The medical director was notified.

How the facility will identify other resident having the potential to be affected by the same deficient practice. All residents have the potential to be effected by the same deficient practice. A direct all staff in-service was conducted on 7/9/14. The nurse managers will monitor for compliance with an audit tool for oxygen in the beauty shop.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility will monitor the beauty shop with an audit tool 3 times a week for 12 weeks. A sign is posted at the door of the beauty shop.

Quality Assurance Plans to monitor facility performance to make sure the corrections are achieved and are permanent. The QA team will review at the next quarterly meeting and as necessary.

Completion 7/~~10~~11/14 change SH (Adm.) 8-7-14 1:15