STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145965	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA CLARA POST ACUTE	**500 WEST MCKINLEY AVENUE DECATUR, IL 62526**

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

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F 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote a dignified existence by failing to provide timely assistance with toileting which resulted in incontinence for one of three residents (R4) reviewed for call lights on the sample list of 13. Findings include: R4's Significant Change Minimum Data Set assessment dated [DATE] documents R4 is continent of bladder. On 7/29/20 at 9:59 AM, V10 Certified Nursing Assistant/Unit Manager stated R4 is totally dependent for transfers, extensive assistance for toileting, and will use call light to to let them know when R4 needs to use the bathroom. V10 stated R4 is continent of urine and bowel. V10 stated R4 doesn't have accidents. On 7/27/20 at 8:47 AM, R4 was in bed with head of bed elevated. R4 stated, it takes them 30-45 minutes sometimes for my call light to be answered. I had back surgery and need help when I have to go to the bathroom, I use the bedpan, sometimes I have to wait so long that I pee (urinate) the bed. It is demeaning, degrading when it happens. It even makes me sick to my stomach sometimes because I have to go so bad. I have even had urinary infections. If they don't answer my light after 30-45 minutes I bang on my bedside table with the end of this knife. (R4 pulled a wooden handled knife out of her bedside table) after beating on the stand for awhile they finally come. It is not any particular shift, It happens on all of them almost every day, it just depends on who is working, they don't have consistent staff each shift, they will switch off in the middle of a shift and I get someone new. R4's Bowel and Bladder record dated 7/1/20 through 7/30/20 documents R4 was incontinent of bladder on the following dates and times: on 7/26/2020 at 1:12 AM, 7/25/2020 at 2:20 AM, 7/24/2020 at 7:59 PM, 7/22/2020 at 12:41 AM, 7/21/2020 at 5:09 AM, 7/20/2020 at 9:19 AM, 7/19/2020 at 11:54 AM, 7/16/2020 at 9:06 AM, 7/15/2020 at 6:25 PM, 7/11/2020 at 6:40 PM, and 7/07/2020 at 8:45 PM. On 7/30/20 at 10:13 AM, V27 Certified Nursing Assistant stated R4 is embarrassed when R4 is incontinent. R4 will say R4 is sorry and that R4 tried to hold it. V27 stated R4 requires more assistance now then when R4 first admitted to the facility. V27 says sometimes V27 is down the hall taking care of someone else and by the time V27 gets down to R4's room, R4 is banging on R4's bedside table. V27 stated if V27 is in a room taking care of someone else it may take longer to get to R4's room.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow their Abuse Prevention Policy by failing to implement procedures for the investigation of an injury of unknown source for one of three residents (R2) reviewed for injuries on the sample list of 13. Findings include: The facility's policy, with a revision date of 11/28/2016, titled Abuse Prevention Program Facility Policy documents, Purpose: The facility prohibits mistreatment, neglect, exploitation, misappropriation of resident property, or abuse of its residents by: Immediately protecting residents involved in identified reports of possible abuse, implementing systems to investigate all reports and allegations of abuse, filing investigative reports. VII. Internal Investigation: 1. All incidents will be documented, whether or not abuse, neglect, exploitation, mistreatment, or misappropriation of property occurred, was alleged or suspected. 2. Any incident or allegation involving abuse, neglect, exploitation, mistreatment or misappropriation of property will result in an investigation. 3. For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: the source of injury was not observed by an person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. If there is an injury of unknown source, the person gathering facts will document the injury, the location and time it was observed, any treatment given, and whether the physician, responsible party and or the Department of Public Health were notified. If the injury is classified as an injury of unknown source the procedures and time frame for reporting and investigating abuse will be followed. 4. Investigation procedures: The appointed investigator will, at minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident, and the resident, if interviewable. Any pertinent medical records or other documents will be reviewed. 8. Final Investigation Report: The investigator will report the conclusion of the investigation in writing to the administrator or designee within five working days of the reported incident. The final investigation report shall contain: name, age [DIAGNOSES REDACTED]. The administrator or designee is responsible for forwarding a final written report of the results of the investigation and any corrective action taken to the Department of Public Health within five working days of the reported incident. R2's medical record documents on 5/15/2020 at 8:52 PM by V6 Social Service Director, BIMS (Brief Interview for Mental Status) Score is 07 meaning- Severe Impairment. R2's medical record documents on 6/24/2020 at 8:33 AM by V23 Nurse Practitioner, asked to see patient this am because of (R2's) multiple bruising to bilateral arms and inner and outer things and lower ext (extremities). R2's medical record documents on 6/24/2020 at 10:30 AM, Resident has multiple discolorations to right, and left arm, left leg and thigh, left hip. NP (Nurse Practitioner) assessed and new orders rec (received). On 7/29/2020 at 11:00 AM, V23 (NP) stated, I was notified on 6/24/2020 that (R2) had bruising to right and left medial inner thighs, and upper extremities. It was a dark purple discoloration. (R2) needed examined, staff sent (R2) to the ER (emergency room). (R2) returned from theER on [DATE] with a [DIAGNOSES REDACTED]. On 7/29/2020 at 11:15 AM V25 Regional Nurse Consultant stated, I remember when (R2) presented with the bruising to upper and lower extremities. NP saw (R2) and ordered tests to rule out something internally going on. On 7/29/2020 at 1:15 PM, V1 Administrator and V25 Regional Nurse Consultant confirmed no investigative report could be located regarding R2's bruising/discolorations to upper and lower extremities observed on 6/24/2020. V1 stated, We are not able to locate a written investigation, there is no documented report/ investigation. If (V26) (previous Administrator) would have conducted a report/ investigation it should have been documented, the final report would have had the conclusion with further interventions, (R2's) care plan would have been updated. There is no documentation the Department was notified.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the State Survey Agency of an injury of unknown source for one of three residents (R2) reviewed for injuries on the sample list of 13. Findings include: R2's medical record

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) documents on 6/24/2020 at 8:33 AM by V23 NP, asked to see patient this am because of (R2's) multiple bruising to bilateral arms and inner and outer things and lower ext (extremities), will send to Hospital for work up. On 7/29/2020 at 11:00 AM, V23 Nurse Practitioner (NP) stated, on 6/24/2020 I was notified (R2) had bruising to right and left medial inner thighs, and upper extremities. It was dark purple discolorations. (R2) was sent to the emergency room , (R2) returned from the emergency roiagnom on [DATE] with a [DIAGNOSES REDACTED]. That ([MEDICATION NAME] without hematuria) would not have caused the bruising/discolorations. On 7/29/2020 at 1:15 PM, V1 Administrator and V25 Regional Nurse Consultant stated, no investigative report could be located regarding (R2's) bruising/discolorations to upper and lower extremities observed on 6/24/2020, there is no documentation the Department was notified. The facility's policy, with a revision date of 11/28/2016, titled Abuse Prevention Program Facility Policy documents: VIII. External Reporting: When an allegation of abuse, neglect, exploitation, mistreatment or misappropriation of property has occurred, the resident representative and the Department of Public Health shall be informed immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation has been reported and is being investigated. 3. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on interview, and record review, the facility failed to investigate an injury of unknown source for one of three residents (R2) reviewed for injuries on the sample list of 13. Findings include: On 7/29/2020 at 1:15 PM V1 Administrator and V25 Regional Nurse Consultant confirmed no investigative report could be located regarding R2's bruising/discolorations to upper and lower extremities observed on 6/24/2020. V1 stated, we are not able to locate a written investigation, there is no documented report/ investigation. If V26 (previous Administrator) would have conducted a report/ investigation it would be written out, the final report would have had the conclusion with further interventions, and (R2's) care plan would have been updated. R2's medical record documents on 6/24/2020 at 8:33 AM by V23 Nurse Practitioner, asked to see patient this am because of (R2's) multiple bruising to bilateral arms and inner and outer things and lower ext. On 7/29/2020 at 11:00 AM, V23 Nurse Practitioner stated, on 6/24/2020 I was notified (R2) had bruising to right and left medial inner thighs, and upper extremities. It was a dark purple discoloration.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** Based on interview and record review the facility failed to assess a pressure ulcer weekly for one of three residents (R*) reviewed for pressure ulcers on the sample list of 13. R8's SBAR (situation, background, assessment, recommendation) report dated 3/3/20 documents R8 has a pressure area to the coccyx. This report does not document a description or measurements of the wound. R8's medical record did not contain an assessment of the wound on 3/9/20. On 7/30/20 at 9:06 AM, V17 Licensed Practical Nurse stated V17 was the wound nurse when R8's pressure ulcer was identified on 3/2/20. V17 stated V17 looked at R8's wound on 3/3/20. V17 stated V17 is unsure why V17 did not document the stage or measurements of the wound. V17 stated R8's pressure ulcer had a black center. V17 stated V17 thinks it measured 4.5 by 3 centimeters. V17 stated V17 saw it written on R8's shower sheet from that day. V17 stated the pressure ulcer was unstageable. V17 is unsure why it wasn't identified prior to that day. On 7/28/20 at 4:07 PM, V25 Corporate Nurse stated R8's pressure ulcer was identified on the 3/2/20. V25 stated she can't answer why there isn't measurements, staging, or characteristics of the wound documented. V25 stated I would expect the wound nurse to measure it. V25 stated was unsure of the stage of the wound. V25 stated the wound physician staged it as a stage four on 3/30/20. The Facility's Wound Assessment Policy and Procedure dated 5/2017 documents a procedure to, 2. A complete wound assessment will be done weekly by a licensed nurse for all wounds, ulcers, and impairments in skin integrity. 3. The comphrehensive or complete wound assessment will be documented on the Nursing Admission Assessment form during the initial assessment and on the Treatment Administration Record weekly thereafter. Facilities using EHR (Electronic Health Records) will complete the initial skin assessment on the Admission/Readmission Observation packet and a Weekly Pressure Ulcer Documentation Observation thereafter. The wound assessment will contain the following information: a. Wound classification (wound type), b. Wound location, c. Pressure Ulcer Staging or description of the extent of the tissue damage. d. Description of the wound bed, drainage, margins/surrounding skin, and odor, e. wound measurements, and f. wound related pain.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide timely assistance to the toilet to prevent incontinence for one of three residents (R4) reviewed for call lights on the sample list of 13. Findings include: On 7/27/20 at 8:47 AM, R4 was in bed with head of bed elevated. R4 stated, it takes them 30-45 minutes sometimes for my call light to be answered. I had back surgery and need help when I have to go to the bathroom, I use the bedpan, sometimes I have to wait so long that I pee (urinate) the bed. It is demeaning, degrading when it happens. It even makes me sick to my stomach sometimes because I have to go so bad. I have even had urinary infections. If they don't answer my light after 30-45 minutes I bang on my bedside table with the end of this knife. (R4 pulled a wooden handled knife out of her bedside table) after beating on the stand for awhile they finally come. It is not any particular shift, It happens on all of them almost every day, it just depends on who is working, they don't have consistent staff each shift, they will switch off in the middle of a shift and I get someone new. R4's Significant Change Minimum Data Set assessment dated [DATE] documents R4 is continent of bladder. R4's Bowel and Bladder record dated 7/1/20 through 7/30/20 documents R1 was incontinent of bladder on the following dates and times: on 7/26/2020 at 1:12 AM, 7/25/2020 at 2:20 AM, 7/24/2020 at 7:59 PM, 7/22/2020 at 12:41 AM, 7/21/2020 at 5:09 AM, 7/20/2020 at 9:19 AM, 7/19/2020 at 11:54 AM, 7/16/2020 at 9:06 AM, 7/15/2020 at 6:25 PM, 7/11/2020 at 6:40 PM, and 7/07/2020 at 8:45 PM. On 7/29/20 at 9:59 AM, V10 Certified Nursing Assistant/Unit Manager stated R4 is totally dependent for transfers, extensive assistance for toileting, and will use call light to to let them know when R4 needs to use the bathroom. V10 stated R4 is continent of urine and bowel.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** Based on interview, and record review, the facility failed to provide nutritional supplements as recommended by the dietitian and failed to monitor food intake for one of three residents (R12) reviewed for weight loss on the sample list of 13. Findings include: R12's weight report dated 5/29/20 through 7/29/2020 documents R12 had an admission weight of 159 pounds on 5/29/20 at 3:19 PM, a weight of 148 pounds on 7/9/20 at 3:08 PM, and a weight of 132.8 pounds on 7/29/20 at 10:09 AM. R12's Progress note dated 7/13/2020 at 8:02 PM written by V22 Dietitian documents, REVIEWED FOR WT (weight) LOSS OF 5.7% PAST MONTH WITH BMI (body mass index) OF 24.6. DIET IS NCS (no concentratred sweets)/REGULAR BUT NO ROUTINE ACCHUCHECKS DONE. NOTED LYMPHATIC WOUND ON LOWER EXTREMITY, OTHER WOUNDS HAVE HEALED. REQUESTING TO D/C NCS (discontinue no concentrated sweets) DIET TO REGULAR/REGULAR, ADD MVI W/MINERALS (multivitamin with minerals), PROSTAT X 3 DAILY TO PROVIDE 300 KCALS (kilocalories), 45 GMS (grams) PROTEIN. WILL MONITOR FOR NEED TO MODIFY FURTHER. R12's Medical Record dated 7/13/20 though 7/30/20 did not document the administration of Prostat three times a day. R12's meal intake log dated July of 2020 does not document an intake for breakfast on 7/1/20 though 7/18/20, 7/20/20, 7/21/20, 7/24/20 through 7/27/20, and 7/29/20. R12's meal intake log dated July of 2020 does not document an intake for lunch on 7/1/20 through 7/29/20. R12's meal intake log dated July of 2020 does not document an intake for dinner on 7/1/20 through 7/29/20. The facility's Feeding A Resident policy dated 5/2017 documents under procedure to, 11. Record intake as required. On 7/30/20 at 10:58 AM, V22 Dietitian stated R12 was weighed on 7/29/20 and she weighed 132.8 pounds. R12 had a significant weight loss. V22 stated V22 added some supplements to help her gain weight on 7/13/20. R12's appetite had been down at that time. Would expect the staff to tell V22 if R12's intake is poor. I would expect the staff to document the intake of the supplement to see if it is effective. The staff should be documenting the food and fluid intake especially for residents who have weight loss.

F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide pain medication for one of three residents (R4)

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) residents reviewed for pain on the sample list of 13. Findings include: On 7/27/20 at 8:47 AM R4 stated I had back surgery and need help. I am supposed to have pain medication every four hours, sometimes I am lucky to get it every 6 or even 8 hours, that happens on all shifts. R4's Care Area assessment dated [DATE] documents, Resident Pain Interview: The resident has indicated the frequency of their pain over the last 5 days as 'almost constant' or 'frequently'. The resident has also indicated the intensity of that pain by: The numeric pain scale being 04 to 10 on the verbal descriptor scale as being 'moderate' to 'very severe'. R4's pain plan of care dated 6/24/20 documents R4 has chronic pain related to back surgery and back pain. This plan of care documents an intervention to administer medications per order. R4's Physician order [REDACTED]. R4's Medication Administration Record [REDACTED]. On 7/30/20 at 9:11 AM, V17 Licensed Practical Nurse stated R4 has a lot of back pain. R4 gets scheduled pain medications. The pain medications are effective. After about 3.5 hours R4 is ready for another pain medication. The [MEDICATION NAME]-[MEDICATION NAME] works well to relieve R4's pain.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a medication was dispensed by the pharmacy for one of three residents (R4) reviewed for pain on the sample list of 13. Findings include: On 7/27/20 at 8:47 AM R4 stated, I had back surgery. I am supposed to have pain medication every four hours, sometimes I am lucky to get it every 6 or even 8 hours, that happens on all shifts. R4's Physician order [REDACTED]. R4's Medication Administration Record [REDACTED]. On 7/30/20 at 9:11 AM, V17 Licensed Practical Nurse stated unavailable from pharmacy means we do not have the medication in the building to give to the resident. The medication cards have a balance remaining on the top of the card. The balance will say zero if we need to get another script. We have to call the physician and get another script. Sometimes the pharmacy will let us know and sometimes they won't.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on interview, and record review, the facility failed to ensure the meal and fluids intake records were complete for three of three residents (R4, R8, R12) reviewed for weight loss on the sample list of 13. Findings include: 1. R4's meal intake log dated July of 2020 does not document an intake for breakfast on 7/1/20 through 7/5/20, 7/11/20, 7/12/20, 7/13/20, 7/15/20, 7/17/20, 7/18/20, 7/20/20, 7/21/20, and 7/24/20 though 7/28/20. R4's meal intake log dated July of 2020 does not document an intake for lunch on 7/1/20 through 7/5/20, 7/8/20, 7/11/20, 7/12/20, 7/13/20, 7/15/20, 7/17/20 through 7/22/20, and 7/24/20 through 7/29/20. R4's meal intake log dated July of 2020 does not document an intake for dinner on 7/1/20, 7/4/20, 7/5/20, and 7/7/20 through 7/29/20. 2. R8's meal intake log dated February of 2020 does not documents any intakes for breakfast for the month of February. R8's meal intake log dated February of 2020 does not document any intakes for lunch for the month of February. R8's meal intake log dated February of 2020 does not document any intakes for supper except for on 2/25/20. 3. R12's meal intake log dated July of 2020 does not document an intake for breakfast on 7/1/20 though 7/18/20, 7/20/20, 7/21/20, 7/24/20 through 7/27/20, and 7/29/20. R12's meal intake log dated July of 2020 does not document an intake for lunch on 7/1/20 through 7/29/20. R12's meal intake log dated July of 2020 does not document an intake for dinner on 7/1/20 through 7/29/20. The facility's Feeding A Resident policy dated 5/2017 documents under procedure to, 11. Record intake as required. On 7/30/20 at 10:58 AM, V22 Dietitian stated would expect the staff to be documenting the food and fluid intake.