STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145611	A. BUILDING _____ B. WING _____	**03/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JAMES WELLNESS REHAB VILLAS	**1251 EAST RICHTON ROAD CRETE, IL 60417**

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 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide consistent and accurate meal intake tracking for 1 resident (R1) at risk for malnutrition. This failure involves 1 of 3 residents reviewed for dining/nutrition out of a sample of 12. Finding include: R1 is a [AGE] year old male admitted to the facility on [DATE] with numerous medical [DIAGNOSES REDACTED]. At the time of admission, admission note of 2/19/20 at 6:09 PM indicates R1 was alert and oriented x 1-2 with some confusion. Initial Nutritional Assessment of 2/20/20 timed at 2:42 PM reflects that R1's estimated caloric and fluid needs were as follows: 1859-2230 kcals (@25-30 kcal/kg (kilogram) 74-82 grams protein (@1-1.1grams/kg); 1859 ml fluid (25 ml/kg secondary to [MEDICAL CONDITION]). R1's admission weight was noted to be 163.6# and he had a BMI (body mass index) of 20.45 (within normal limits-WNL). R1's care plan for nutrition identifies that R1 required a mechanically altered diet due to dysphagia. The goal of this care plan is for R1 to maintain his body weight of 164#. Initial dietary assessment reflected an admission weight of 163.6# on 2/19/20. The only approach for this goal was R1's recommended diet (regular pureed diet). On 3/11/20 at 9:50 AM, V2 (DON) stated that the facility staff monitor the dining room where the majority of residents eat and/or are fed. They observe how residents eat and are to report to the nurse if someone doesn't eat well. They are not required to record the amount a resident eats or drinks. The nurse should document about their appetite. If a resident's intake is poor for more than 2 meals they are to call the physician. They depend on the CNAs (certified nurse's aids) to tell the nurse how the resident is eating and drinking. Nurse's note from 2/20/20 at 7:13 PM reflects that R1's appetite was good for supper and he was compliant with his meals. There is no quantification of what good means, and no percentages of intake were given. There is no mention of fluid intake, Nursing note from 2/21/20 at 3:42 PM for R1 also reflects that his appetite was good for all meals. There were no percentages documented nor quantification of R1's intake and no mention of fluid intake. There was no further mention of R1's appetite or intake through R1's discharge to the hospital on [DATE]. On 3/11/20 at 2:55 PM, V9 (Licensed Dietician) stated that she expects that if a resident is not eating, either she or the physician will be notified. She talks to staff to see how people are eating. She only saw R1 for his initial assessment. If a note says a resident is eating well, she thinks that would mean 50% or more and if it says the resident ate good, to her that would mean 75% or greater. She hopes good means the same thing to everyone but she can't be sure of that. V9 stated that she believes that staff document the percentage of meals eaten. On [DATE] at 2:30 PM, V6 (RN) stated that on 2/24/20, the day R1 was sent to the hospital, she came on duty at 2:30 PM. She recalled R1's family coming up to the desk and asking how R1 had eaten that day. V6 stated that she had to refer him to the day nurse, who stated that R1 hadn't eaten much for either meal. There is no documentation about R1's meal intake on 2/24/20. On 3/11/20 at 2:00 PM, V11 (CNA) stated that the CNAs in the dining rooms will let the nurse's know how the residents eat, but they don't record the intake. They try to use percentages when reporting meal intake, On 3/12/20 at 10:20 AM, V4 (LPN) stated that on the day R1 was sent to the hospital, R1 ate his food. (This is in contrast to what V6 stated). She was surprised to learn the next day that R1 went to the hospital. V4 stated that when the CNAs report about a resident's intake, they will report percentages eaten. Nursing note of 2/24/20 timed at 4:20 PM documented that V12 (MD for R1) was in the facility and saw R1, He ordered stat lab work, a palliative consult and to encourage fluids. On 3/11/20 at 1:35 PM V12 stated that he ordered the staff to encourage fluids for R1 because he had been told that R1 wasn't eating. At the time he ordered the labs, he was awaiting those results to determine if R1 was dehydrated, which will happen if you don't eat or drink. According to V12, R1's family insisted on sending R1 to the hospital rather than getting lab work done. Hospital emergency room [DIAGNOSES REDACTED].

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.