STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F 324	Continued From page 17 of fall. R2 was confused as per normal and there was no height adjustment of bed at time of fall. Incident Report of 10-19-04 at 4:45AM shows that bed alarm sounded and when staff entered the room R2 was sitting on the floor with right great toe having 2 lacerations and blood on the floor. Report documents that R2 was confused and bed rails were not in use at time of fall. Interview with E1 on 9-15-05 at 10AM confirmed that R2 had Alzheimers and was confused yet facility was using alarms to remind R2 not to get up without assistance. E1 confirmed facility did not implement new interventions to keep R2 from falling out of bed even though R2 had history of falls and had fallen 2 times in October 2004. R2 fell again and sustained two lacerations to Right great toe.	F 324		
F9999	FINAL OBSERVATIONS LICENSURE 300.610a) 300.1210a) 300.1210b)4) The facility's policies shall be followed in the operating the facility. 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. Personal care shall be provided on a 24-hour, seven day a week basis.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 18 These regulations are not met, as evidenced by the following: Based on interviews, observations, and record review, the facility failed to ensure that R1 was free from physical abuse. The facility failed to immediately separate R1 from Z3 on 9/2/05 when Z3 was observed to be holding a plastic bag across R1's face. The facility failed to call police or intervene in a timely manner which resulted in Z3 repeatedly placing a plastic bag over R1's face. Findings include: Review of the admission sheet identifies R1 as a 76 year old male admitted to the Alzheimer's Unit on 3/11/05, with a diagnoses of Alzheimer's Disease. On 8/21/05, according to the physician's order sheet (POS), R1 was placed on Hospice services due to a decline in general health, but remained on the secured unit. A review of R1's assessment, dated 8/31/05, indicated R1 was totally dependent on staff for all activities of daily living and was cognitively impaired. Z3 is identified as R1's Power of Attorney. Review of an incident report dated 9/2/05, at 0020 (12:20am), E6 certified nurses aide (CNA), entered R1's room and observed Z3 at R1's bedside "with what appeared to be a plastic bag over res (resident's) face". The incident report continues to state Z3 pulled the bag away. The incident report indicates at 0045 (12:45am), "staff visually supervising res." but does not reflect any other action or intervention by facility staff to prevent further attempts. Vitals documented to be 114/66, Pulse 130, respirations 16 with Pulse	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 19	F9999		

oximetry at 95% on room air. Review of the nurses notes reflect the same entry.

Review of the facility's investigation dated 9/2/05, includes an interview with E4, Registered Nurse (RN), who said she assessed and gave medication to R1 between 11:30-11:45pm on 9/1/05 and reported that Z3 was sitting at the opposite side of the bed. She noted nothing unusual at the time. According to the interview, at "approximately" 12:10am on 9/2/05, E4 went back to R1's room and saw that the door was partially open with the recliner behind the door preventing it from opening all the way. E4 stated she "didn't think much of it and thought that he was just trying to block the light". She continued to state she heard plastic rustling but didn't see anything and Z3 indicated that R1 was nauseated and having dry heaves. E4 placed a towel under R1's face and indicated that R1 had not had any nausea reported throughout the day. The report continues to "approximately" 12:30pm when E6 reported the plastic bag over R1's face to her. E 4 describes E6 as being "visibly upset, crying" advising her that she couldn't go back into the room as Z3 was trying to hurt R1. The report then states E4 talked to the other nurse and requested E7, a male CNA, to come to the unit and assist with monitoring the resident and visitor . E4 then reported calling administrative staff and at 12:45am, "while making phone calls", E7 called her on the intercom and advised that Z3 " had been observed doing it again". E4 then called 911. The police arrived at 12:50am and when entering the room, again observed Z3 to have a plastic bag over R1's face.

On 9/9/05 at 6:40am, E4 described E6 as " hysterical" when she initially reported the incident to her. E4 stated after she calmed E6 down, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 20	F9999		

sent her back to R1's room to monitor the situation. E4 then stated she left the unit to confer with the other nurse E5, Licensed Practical Nurse (LPN), as to what to do. E4 stated she was "in shock" and wanted to take a couple of minutes to think about it although she " was sure it had happened because of E6's demeanor". E4 stated she left the Alzheimer Unit and went to the nursing station on the skilled unit so Z3 could not hear her discuss the situation with staff and management. E4 stated she sent E7 down to assist E4 and started phoning administration. She stated both E7 and E6 were stationed outside the room and kept going in to provide care to R1 and his room mate when they heard the plastic bag rustling. E4 stated she did not go down to the room following the initial report at 12:20am. E4 stated the number one priority was the resident but she had never encountered anything like this before. E4 also indicated she didn't want Z3 to leave the unit and wanted to keep an eye on him to see if it was an "isolated attempt." E4 confirmed that while she was on the phone with E1, Administrator (ADM), E7 called over the intercom and indicated another attempt had been made by Z3. E4 then stated she called 911. The police arrived, proceeded down to R1's room as E6 (who was in the hallway outside R1's room) motioned for them to hurry. E6 indicated that Z3 was making another attempt to place the bag over R1's face.

E4 acknowledged herself as the charge nurse who was responsible for staff and residents. E4 stated she did not want to falsely accuse someone of attempted murder "but knew after he (Z3) had made several attempts" that he would blatantly continue. E4 stated E1 had encouraged her at least twice over the phone to go down to R

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 21	F9999		

1's room, pull Z3 aside and inquire about what the "significance of the plastic bag was" but stated she was fearful for both resident and staff not knowing Z3's demeanor at the time. E4 stated she did not confront Z3 at any time nor did she go down to the room prior to the arrival of the police. E4 also stated R1 was assessed following the police arrival and the vitals documented at 12:20am in the report and nurses notes were actually vitals done following the police arrival at 12:50am .

E4 described R1 on 9/1/05 and 9/2/05 as not being verbally responsive but responded to painful stimuli and didn't appear to be conscious of what was going on as his eyes never opened. E4 stated R1 had taken some sips of water earlier but had not had anything to eat and she did not observe any gagging or vomiting. E4 stated R4 did react to the attempts as his heart rate increased to 130 but returned to pre-incident norms (80 - 88) as the morning progressed following the incidents.

On 9/9/05 at 6:20am, E6 stated she told the nurse (E4) at 12:20am on 9/2/05 that she saw Z3 holding a plastic bag over R1's face. E6 stated E 4 told her to go back to the room and keep it in sight as she called authorities and management. E4 stated she and E7 remained in the hallway outside R1's room and would enter periodically when they heard the plastic bag rustling. E6 state Z3 barricaded the doorway with a chair allowing the door to be opened only 1 - 1 1/2 feet. E6 stated every time she left the room, it was like "clock work" as she would hear the bag rustling again. E6 stated she saw Z3 with the plastic bag over R1's face at least two more times with the last attempt being when police entered the room. E6 stated she and E7 were the only ones on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 22	F9999		

unit and that E4 did not come to the room until the police arrived. E6 stated R1 did not appear to be gagging or vomiting as alleged by Z3 earlier in the evening nor did he mention anything about it to her earlier that night.

On 9/9/05 at 6:20am, E7 confirmed that he and E6 repeatedly entered R1's room and stated they would stay within eyesight of the doorway itself making excuses to enter the room when they heard the plastic bag rustling. E7 stated he did not actually see the plastic bag over R1's face but did see it near his face. E7 recalled entering the room at least 4 times but had to leave the last time as "he knew what Z3 was doing". E7 stated it was then that he called E4 on the intercom to notify her that the attempts were continuing. E7 confirmed that Z3 did block the doorway with a chair and E4 did not go down to the room until after the police arrived. E7 recalled Z3 earlier in the evening on the skilled unit of the facility as if seeing what staff were here. E7 did indicate R1's pulse oximeter reading dropped immediately after the incident but came back up later.

On 9/12/05 at 2:34am, E5, Licensed Practical Nurse (LPN), stated she was working on the skilled unit, 10pm to 6am on 9/1/05 to 9/2/05, when the incident occurred. E5 stated E4 called her on the intercom and asked her to meet her down the hall from the Alzheimer's unit. E4 told E5 that E6 had seen Z3 with a bag over R1's face . E5 stated they sent E7 down to assist E6 and both nurses walked back to the skilled unit nursing station where E4 called E1, the Administrator and they discussed calling the police. She said E7 then called from the unit and stated Z3 had made another attempt. E4 then called 911. E5 said she did not go down to R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 23	F9999		

room until after the police arrived but thought E4 had gone into the room immediately following the first allegation at 12:20am. E5 also stated she assumed E7 would remain in R1's room and did not know he was monitoring R1 from the hallway. E5 stated she sent E9, CNA, down to R1's room to take vitals for E4 after the police arrived.

Interview with the Police officers on 9/8/05 at 7:45am and 9/11/05 at 9:55am indicated they received the call at 12:47am and information provided was sketchy. Both stated they went to the skilled unit nurses station to the left when they entered the building. Z1 was handed the phone while Z2 spoke with the care givers about R1. Z1 indicated the member of management on the phone wanted the police to wait as she wanted the nurse to go in first. Z1 was unable to identify the member of management he spoke to. However, after receiving the information from the care givers regarding the plastic bag over R1's face, Z2 proceeded directly to R1's room on the unit. Z2 indicated the door was blocked with a chair and "not easily opened" when they entered and Z3 was at R1's bedside holding a plastic bag over his face. Z2 stated he noticed R1's feet moving in the bed when he entered and was " gasping for air" after the bag was removed.

On 9/9/05 at 2pm, E8, LPN on 2-10pm shift on 9/1/05 stated R1 had just had his pain medication increased that evening and did not appear to be in pain as he exhibited very little response. E8 stated she was unaware of him having any nausea, gagging that night and R1 appeared to be comfortable. E8 did recall Z3 as being at the facility that night and stated she visited with him for a while.

On 9/12/05 at 10:20am, E9, CNA, stated she was working on the skilled unit but followed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 24	F9999		

police down to R1's room on the unit. E9 stated she took R1's vitals for E4 after the police removed Z3 from R1's bedside. E9 recalled R1 to be barely responsive and very sluggish.

Interview with E1 on 9/9/05 at 12:45pm indicates she did ask E4, on the phone, to go down to the room and pull Z3 out of the room and ask him about the plastic bag prior to the police going down. E1 states she feels the staff handled the situation correctly as all staff were unsure as to Z3's demeanor at the time and didn't know what he'd do. E1 states R1 was protected as staff were maintaining visual contact with the room. However, observation of the room indicates that the top of R1's bed was not within visual range as the bathroom wall would have occluded it and Z3 had the door partially blocked with a chair. E1 acknowledged that E4 did not go down to R1's room to intervene following the first observation nor did she ensure that Z3 was separated from R1 at any time until the police arrived a half hour later.

On 9/15/05 at 8:35am, E2, Director of Nursing (DON), stated she spoke with E4 about the incident on 9/14/05. E2 stated E4 should have separated Z3 and R1 immediately following the allegation.

According to the facility's policy revised 9/20/02 on "Abuse and Neglect: Detection and Prevention Program", each resident has the right to be free from abuse. The policy's definition of Abuse is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish". The policy states the facility " prohibits mistreatment, neglect or abuse of residents by an individual. This includes the deprivation by an individual including a caretaker,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145721	A. BUILDING _____ B. WING _____	C 09/16/2005

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 PRECEEDED 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) COMPLETION DATE
F9999	Continued From page 25 of goods or services necessary to attain or maintain physical, mental and psychosocial well-being. This presumes that instances of abuse of all resident, even those in a coma, can cause physical harm, or pain or mental anguish". Section VI states "Residents who receives services must be protected from any service interruption, restrictions, and all other forms of retaliation. Separation will be used to protect a resident from abuse and/or neglect by any suspected perpetrator." The facility failed to separate Z3 from R1 following the initial allegation of E6 at 12:20am on 9/2/05. Although E6 and E7 were directed to monitor the room following the first incident and did enter the room several times, Z3 remained at R1's bedside and made repeated attempts to place a plastic bag over R1's face over the next 27 minutes until the police arrived. E4 stated in her interview that she was fearful for the resident and staff but did not call 911 immediately following the first alleged attempt at 12:20am but waited until 12:47am. The facility also failed to provide immediate assessment of R1 following the initial incident and subsequent attempts until the police arrived.	F9999		