STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146017	A. Building B. Wing	08/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Illini Heritage Rehab & Hc	1315 Curt Drive, Suite B Champaign, IL 61821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on observation, interview and record review, the facility failed to follow physician orders for 3 of 3 residents (R1, R2, R3) reviewed for nursing care in the sample of 3. These failures resulted in R1 being admitted to a local hospital with chest incision and right lower leg infection requiring intravenous antibiotic medication. Findings include: R1's Physician Order Sheet (POS) dated 5/26/22 through 5/31/22, document R1's diagnoses as: Moderate to Severe Mitral Regurgitation, Non-stemi Myocardial Infarction, and Non- Rheumatic Aortic Valve Insufficiency. R1's Emergency Department notes dated 5/31/22, document R1's diagnoses as: Hypertension, Coronary Artery Disease, recent Triple Bypass and Mitral Valve Repair. R1's hospital discharge transfer orders dated 5/26/22, document R1 going to a Skilled Nursing facility on this day with a diagnosis of status post Coronary Artery Bypass Graft. R1's incomplete Nursing Admission assessment dated [DATE], documents R1 arrived at the facility at 1:45 PM. There is no documentation in R1's Nursing notes for R1 admission. The only Nursing Notes in R1's medical record are on 5/28/22 at 2:40 PM, 5/29/22 at 3:30 PM, 5/29/22 2-10 PM, 5/30/22 at 1:40 PM, 5/30/22 at 10:00 PM, 5/31/22 at 4:00 AM, and 5/31/22 at 10:50 AM. R1's Medical Administration Record (MAR) dated 5/26/22, documents no medications were given to R1 on this date. The medications include: Citrucel, Pantoprazole, Atorvastatin, Certrizine, Finasteride,Warfarin, Docusate, Ferrous Sulfate, and Testosterone not given 5/27/22 through 5/31/22. R1's MAR documents an order on 5/29/22, for Clindamycin 300 milligrams (mg) by mouth three times a day for 7 days. This medication was not given on on 5/29/22. This medication was observed to be in the facility's convenience box in the medication room on 8/4/22 at 11:30 AM, having 6 capsules available for use. An order for Probiotic by mouth twice a day for 14 days was also not given on 5/29/22 and was not given on 5/30/22, noon dose. An order on 5/30/22 was given to discontinue Clindamycin (due to allergy) and start Doxycycline 100 mg by mouth twice a day for 7 days. R1's MAR documents Doxycycline only being given on 5/31/22 at 1200 noon. Doxycycline was also observed in the convenience box on 8/4/22 at 11:30 AM, having 6 capsules available for use. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's discharge orders from 5/26/22 document orders for a fluid restriction of 2 liters or less in 24 hours, which there is no documentation of this order being carried out 5/26/22 through 5/31/22. There are no dietary/nutrition notes in R1's chart. Another order from R1's discharge orders documents to walk a minimum of three times a day. On 8/9/22 at 9:27 AM, V8 Physical Therapy Assistant (PTA) stated R1 walked 175 feet one time on 5/29/22 and walked 25 feet one time on 5/30/22. An order from R1's discharge orders documents to use the incentive spirometer 10-15 breaths every 1-2 hours, there is no documentation of this being done 5/26/22 through 5/31/22. These discharge orders also document wound care for chest tube care - wash daily and cover with dry dressing, examine wounds everyday; chest incision - use clean washcloth, wipe down chest incision once with soap and water, use another clean washcloth and rinse incision starting at the top and going down incisions, pat dry with clean towel; leg incision - clean each leg incision separately, start with lowest incision, wipe each incision from top to bottom, dry incisions with clean washcloth, leave open to air unless drainage, apply gauze 4 x 4 to any incisions where skin touches groin or draining, change everyday as needed, also apply 4 x 4 or absorbent cloth between and under breasts. There is no documentation in R1's chart documenting these orders were carried out. There is no Treatment Administration Record (TAR) in R1's medical record so no documentation of any treatments being completed. R1's Nursing Notes dated 5/31/22 document, R1 was sent to the Emergency Department (ED) on 5/31/22 at 10:50 AM due to R1 experiencing discomfort with right lower extremity with redness, swelling, and warmth. On 8/4/22 at 10:21 AM, V4 Nurse Practitioner, stated no one saw R1 from 5/26/22 until 5/31/22. V4 stated R1 should have been seen within 1-2 days especially the reason R1 was at the facility (post-coronary artery bypass graft). V4 stated R1 should have been seen before 5/31/22 by myself (V4) or the doctor V5. V4 stated R1 needed to be sent to the ED due to R1's sternum surgical area looking infected and had drainage. V4 stated V4 did not look at R1's legs at that time. V4 stated V4 did not do any type of note in R1's chart about what was going on with R1. R1's ED notes dated 5/31/22, document: patient had triple bypass and mitral valve repair on 5/19/22, discharged to long term care facility on 5/26/22, sent to ED for concern for infection at the surgical sites, patient had wound care nurse see R1 over the weekend and there was concern for infection in R1's lower midsternal surgical wounds, prescribed doxycycline on 5/29/22 but has yet to receive any antibiotic, patient does have redness to the right leg and redness with some drainage from the abdomen, R1 and wife V6 noted over the weekend wound was draining and saturated through R1's shirt, R1 notes R1 has some redness to right medial calf where graft was performed. R1's hospital notes dated 5/31/22, document R1 admitted to the hospital with Vancomycin intravenously. R1's Hospital notes from 6/3/22 document R1's right lower leg has a Klebsiella Oxytoca infection and receiving Rocephin and Vancomycin and Ceftriaxone due to positive swab of right lower leg. These hospital notes also document R1's right lower leg was cleaned with betadine and using a scalpel, the surgical site was opened and old sutures removed, small amount of murky fluid drainage present, wound cleaned and packed with saline wet to dry dressing and plan for wound vac placement on 6/4/22. R1's Hospital Discharge Summary dated 6/14/22, documents R1 being in the hospital from 5/31/22 through 6/14/22 with positive blood cultures growing two different organisms and needing two antibiotics, vancomycin and ceftnizone, wound cultures growing Klebsiella Oxytoca in right lower leg surgical site, transitioned to Keflex, placed on wound vac and went home with antibiotic and wound vac on 6/14/22. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/4/22 at 11:30 AM, V2 LPN, stated there is no treatment sheet or as needed (PRN) sheet for R1 that V2 can find. V2 stated if it wasn't charted, it wasn't done. V2 stated there is a convenience box in the medication room where there are several antibiotics and other medications for immediate use. V2 stated there is no nursing note for R1's admission and there was no complete assessment done including a body assessment. V2 stated it doesn't look like the treatment orders for R1 were clarified and they were not even being done because there is no TAR sheet to even document they were being done. On 8/8/22 at 8:45, V2 stated the Treatment Administration Record for R1 shows treatment for R1's chest wound as being done on 5/29/22 and 5/30/22 for the 2-10 PM shift but no other treatments were done. On 8/4/22 at 2:40 PM, V1 Administrator stated it looks like there was a failure all around for R1's admission and V1 cannot tell who did the original admission. On 8/4/22 at 3:25 PM, R3's wound dressing was observed with no date, time, or initials on bandages. At this same time R3 stated R3's wound dressings are not changed every day. On 8/4/22 at 3:34 PM, R2 right leg wound dressing is soaked through to the linens on R2's bed, no date, time, or initials on bandages. At this same time R2 stated R2's wound dressings do not get changed everyday. The facility's Resident Council Meeting Minutes notes dated 5/20/22, document nurses not doing treatments. The facility's undated Nursing Documentation Guidelines Policy, documents three day documentation on every shift is required on all new admissions, MD should be notified after one missed treatment or one missed medication, be aware of facility policies and procedures on draining wounds; skin, wound, and pressure ulcer documentation - regular observations of skin surfaces, the progress, deterioration of any new problems; medication administration - the date, time, and initials of the person administering the medications is to be documented on the Medication Administration Record and PRN (as needed) sheets; fluid intake documentation - the amount of fluid consumed at each meal and between meals; treatment documentation - date and time each treatment administered, name and initial of person administering treatments, treatments should be documented on the Treatment Administration Record (TAR). The facility's undated Admissions Policy documents each resident shall have a complete physical examination within 72 hours after admission, The facility's Conformance with Physician Medication Orders Policy dated Reviewed 9/27/17, documents all medications shall be given as prescribed by the physician at the designated time. The facility's Medication Administration Policy date Revised 11/18/17, documents medications must be prepared and administered within one hour of the designated time, check medications against the resident's allergy list, and document any medication not administered for any reason on the back of the MAR with the date, the time, the medication and dosage, and reason for omission and initials.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 35380 Based on observation, interview, and record review, the facility failed to employ the services of a Registered Nurse eight consecutive hours every day and failed to employ the services of a full time Director of Nursing. This failure has the potential to affect all 43 residents residing in the facility. Findings include: On 8/4/22 at 8:40 AM, V1 Administrator, presented the facility's Daily Roster documenting 43 residents residing in the facility. On 8/9/22 at 3:00 PM, V11 Regional Nurse, presented time cards for 5/26/22 through 5/31/22 for Registered Nurses (RN) and a master schedule by shift 7/1/22 through 8/8/22 for RN's. The time cards dated 5/26/22 through 5/31/22, document V12 RN worked on 5/27/22 and 5/31/22 for at least 8 hours a shift. This same time card documents V9 RN worked on 5/31/22 for at least 8 hours. These same time sheets indicate there was no RN coverage for 8 hours a day on 5/26/22, 5/28/22, 5/29/22, and 5/30/22. The Nursing Master Schedule dated 7/1/22 through 8/8/22, document no RN coverage for 8 hours a day on the following days: 7/4/22, 7/9/22, 7/10/22, 7/18/22, 7/21/22, 7/23/22, 7/24/22, 7/29/22, 7/31/22, 8/1/22, 8/4/22, 8/7/22. On 8/9/22 at 3:26 PM, V11 RN/Regional verified there were no RN's working on those dates. V11 also verified there is no Director of Nursing (DON) at the facility and the last DON V10, that worked at the facility, worked 4/20/22 through 5/6/22, and there has not been a DON as of 5/6/22. On 8/4/22, 8/8/22, and 8/9/22, throughout the days, there was no DON seen present in the building. The facility's Infection Control Surveillance and Monitoring Policy dated Reviewed 12/7/18, documents monitoring of the day to day operation of the Infection Control Program will be conducted by the DON. The facility's Facility Assessment reviewed 4/4/22, documents no one holding the DON position. The facility's Midnight Census Report presented on 8/4/22, documents 43 residents residing in the facility.