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	12/07/2022

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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32853 Based on record review and interview the facility failed to complete wound treatments as ordered on multiple days for one of four residents (R2) reviewed for wounds in the sample list of nine. Findings include: The facility's Aseptic Wound and Skin Treatment Procedure with a revised date of January/2018 documents, Purpose: To prevent contamination of the wound, protect wound from mechanical injury, to stimulate, restore, and promote circulation and healing, prevent further deterioration of skin tissue, prevent necrosis of deeper body structures, and to promote resident comfort. Document procedure on treatment sheet. R2's Physician Order Sheet (POS) dated 8/1/22 through 8/31/22 documents diagnoses including Anxiety, Falls, Dementia, Senile Degeneration of Brain, Weakness and Chronic Pain. This POS documents a treatment order for the affected cheek to apply antibiotic cream to the area twice daily. R2's Treatment Administration Record (TAR) dated 8/1/22 through 8/31/22 documents the order for the affected cheek to apply povidone iodine twice a day. This TAR also documents an order to apply zinc oxide to R2's buttocks twice daily and as needed. This TAR documents both of these treatments were not signed out as completed on 8/10/22, 8/11/22, 8/12/22, 8/14/22, 8/15/22, 8/16/22, 8/17/22, 8/19/22, 8/20/22, 8/21/22 and 8/22/22. On 12/7/22 at 1:45 PM, V3 confirmed the nurse are to sign their initials on the Treatment Administration Record when they complete a treatment. V3 confirmed R2's Treatment Records are not complete.

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.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32853 Based on observation, interview and record review the facility failed to complete pressure ulcer treatments as ordered, complete weekly pressure ulcer monitoring, thoroughly assess pressure ulcers upon admission, obtain treatment orders for a newly identified wound and have documentation of identification of a new wound for two of four residents (R5, R4) reviewed for pressure ulcers in the sample list of nine. This failure resulted in R5's unstageable pressure ulcer deteriorating and increasing in size. Findings include: The facility's Pressure Sore Prevention Guidelines policy with a revised date of January/2018 documents, Any resident scoring a High or Moderate risk for skin breakdown will have scheduled skin checks on the Treatment Record. Skin checks will be completed and documented by the nurse. The facility's Aseptic Wound and Skin Treatment Procedure with a revised date of January/2018 documents, Purpose: To prevent contamination of the wound, protect wound from mechanical injury, to stimulate, restore, and promote circulation and healing, prevent further deterioration of skin tissue, prevent necrosis of deeper body structures, and to promote resident comfort. Document procedure on treatment sheet. 1.) R5's Physician's Order Sheet dated 11/1/22 through 11/30/22 documents diagnoses including Skin Picking, Advanced Dementia, Neuropathy, Obesity and Diabetes. R5's Physician's Order dated 11/30/22 documents a treatment order for the left heel to cleanse with normal saline, pat dry, apply calcium alginate, cover with a foam dressing, secure with rolled gauze and change daily. R5's Physician's Order dated 11/30/22 documents a treatment order for the right buttock to cleanse with normal saline, pat dry, apply calcium alginate, cover with a bordered foam dressing and change daily. R5's Physician's Order dated 11/30/22 documents a treatment order for the right heel to cleanse with normal saline, pat dry, cover with a foam dressing and change three times a week. R5's Treatment Administration Record dated 12/1/22 through 12/31/22 documents an order to apply skin protective wipe every shift and documents three shifts, 10:00 PM to 6:00 AM, 6:00 AM to 2:00 PM and 2:00 PM to 10:00 PM. There are not signatures indicating this treatment was completed at all in December. This Treatment Administration Record documents an order for the right heel to cleanse with normal saline, pat dry, apply three times a week and documents to be completed on the 10:00 PM to 6:00 AM shift and is to be completed on 12/2/22, 12/5/22, 12/7/22 and 12/9/22. This treatment is not signed out as completed on 12/5/22. On 12/6/22 at 1:55 PM, V12 Licensed Practical Nurse removed R5's left heel protector boot and the dressing that was on the left foot was dated 12/3/22. The dressing had drainage soaking through. V12 confirmed the date was 12/3/22 and was supposed to have been changed on 12/5/22 but was not and confirmed there was drainage soaking through the dressing. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	R5's medical record contains Wound Evaluations from V18 Wound Physician. R4's Wound Evaluation dated 10/26/22 documents the Unstageable Left Heel wound measured 4.5 cm (centimeters) x (by) 8 cm. There is no other wound measurements or assessments until 11/16/22, 21 days later. R5's Wound Evaluation dated 11/16/22 documents the Unstageable Left Heel wound measured 6.5 cm x 10 cm x 0.1 cm and wound progress is documented as Deteriorated. On 12/6/22 at 2:35 PM, V3 Regional Administration confirmed that R5's chart did not contain a thorough assessment of R5's wounds on admission. V3 stated V3 could only find the depth of R5's Left Ischium wound and no other measurements or characteristics. 2.) R4's Physician's Order Sheet (POS) dated 12/1/22 through 12/31/22 documents diagnoses including Left Ischium Stage Four Pressure Ulcer, Cellulitis of Left Lower Extremity, Diabetes Type 2, Infected Wound and Chronic Kidney Disease. R4's POS documents treatment orders dated 11/30/22 for the Left Ischium to cleanse with normal saline, pat dry, pack with rolled gauze soaked in 1/4 strength bleach solution, cover with abdominal pad and change twice a day; the Sacrum to cleanse with normal saline, pat dry, apply calcium alginate, cover with foam dressing and change daily; the right ankle to cleanse with normal saline, pat dry, apply calcium alginate, cover with foam dressing and change three times a week; the left heel to cleanse with normal saline, pat dry, apply foam dressing and change three times a week; the left anterior leg to cleanse with normal saline, pat dry, apply calcium alginate, cover with an abdominal pad and change three times a week; the right anterior leg to cleanse with normal saline, pat dry, apply calcium alginate, cover with a silicone foam bordered dressing and change three times a week. R4's Nursing Admission assessment dated [DATE] at 8:15 PM does not document a thorough assessment of all of R4's wounds. The area on the left Ischium has no measurements for width or length. The depth is measured at 7 centimeters but no other characteristics are identified. R4's Treatment Administration Record (TAR) dated 11/18/22 through 11/30/22 documents R4 daily skin check was not signed off as completed on 11/22/22 and 11/30/22. This TAR documents R4's Right Ischium treatment was not signed off as completed on the evening shift of 11/22/22 and 11/23/22 and both shifts on 11/30/22. R4's TAR documents R4's Left Lower Extremity treatment was not signed off as completed on 11/30/22. R4's TAR documents R4's Left Heel treatment was not signed off as completed on 11/30/22. R4's TAR documents R4's Right Leg and Right Foot treatment was not signed off as completed on 11/22/22 and 11/30/22. R4's TAR documents R4's Right Heel treatment was not signed off as completed on 11/22/22 and 11/30/22. R4's TAR documents R4's Left Ischium treatments was not signed off as completed on 11/22/22 both shifts, 11/23/22 both shifts, 11/24/22, 11/25/22, 11/26/22, 11/27/22 on the evening shift and 11/30/22 on both shifts. R4's TAR documents R4's Left Buttock treatment was not signed off as completed on 11/22/22, 11/23/22 and 11/30/22. R4's TAR dated 12/1/22 through 12/31/22 documents R4's Left Ischium treatment was not signed off as completed on 12/5/22 on the evening shift. On 12/5/22 at 4:00 PM, R4 stated that the nurses do not change R4's dressing as they are ordered to be changed. R4 stated the dressings were not changed last night (12/4/22) and had not yet been changed this day (12/5/22). R4 stated R4 really wants the wounds to heal so that they do not have to be treated when R4 goes home. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's Physician visit with V17 R4's Physician on 11/22/22 documents R4 was concerned that R4's dressings have not been changed consistently since R4 was admitted to the facility. On 12/6/22 at 8:15 AM, V8 Licensed Practical Nurse (LPN) completed dressing changes for R4. When V8 removed R4's incontinent brief and there was a new open area on the right buttocks approximately 0.5 cm (centimeters) circular shape. V8 stated that V8 noticed that area yesterday and left a message for V18 Wound Physician regarding this new area but V8 stated V8 has not received a reply back. V8 confirmed there is no treatment order for this area and V8 did not complete a treatment for this area. V8 left this new area open and put a clean incontinence brief on R4. R4's Minimum Data Set (MDS) dated [DATE] does not document any of the wounds that R4 had on admission. On 12/7/22 at 10:45 AM, R4 stated that the nurses miss doing some of R4's treatments. On 12/7/22 at 1:00 PM, V8 LPN confirmed there is still no treatment orders for R4's new wound on R4's buttocks. V8 stated that V18 Wound Physician will be back to the facility on [DATE]. The facility's Resident Council Meeting Minutes dated 9/23/22 documents concerns regarding wound not being done. On 12/7/22 at 1:45 PM, V3 confirmed the nurse are to sign their initials on the Treatment Administration Record when they complete a treatment. V3 confirmed the Treatment Records are not complete.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32853 Based on observation, interview and record review the facility failed to investigate a fall and failed to determine the root cause for falls for two of three residents (R6, R1) reviewed for falls in the sample list of nine. Findings include: The facility's Fall Prevention policy with a revised date of 11/10/18 documents, Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. 5. Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. 6. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM (Assess, Intervene, Manage) for Wellness along with any new intervention deemed to be appropriate at the time. The unit nurse will also place any new intervention on the CNA (Certified Nursing Assistant) assignment worksheet. 7. Report all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan. The facility's undated Fulfilling Fall Prevention Responsibilities policy documents, Charge Nurse: Conduct a 'Fall Huddle' with staff after the fall to obtain important information about the fall to help identify the cause of the fall. DON (Director of Nursing) Quality Assurance Analysis and Insure documentation of the root cause and new intervention is recorded in the medical record during the Morning QA (Quality Assurance) Meeting. 1.) R6's Nurse's Notes dated 10/23/22 at 5:20 PM documents, (R6) found sitting on floor mat next to bed, leaning against w/c (wheelchair). (R6) has not c/o (complaints of) pain, no swelling or bumps, no evidence of hitting (R6's) head. Dr. Notified. signed by V19 Licensed Practical Nurse. The facility's Fall Analysis Log does not document this fall. On 12/7/22 at 11:14 AM, V3 Regional Administration confirmed there is no investigation of R6's fall on 10/23/22. The facility's Fall Analysis Log documents R6 had a fall on 11/5/22 and the facility did not determine a root cause. This log documents a fall for R6 on 11/17/22 and the facility did not determine a root cause for this fall. The facility documented the root cause as R6 had poor safety awareness. 2.) R1's Physician's Order Sheet dated 11/1/22 through 11/30/22 documents diagnoses including Acute Diastolic Heart Failure, Hemodialysis, Acute Metabolic Encephalopathy, End Stage Renal Disease and Diabetes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan dated 9/20/22 and provided on 12/5/22 documents R1 has risk factors that require monitoring and intervention to reduce potential for self injury with interventions for non-skid footwear, lock wheelchair brakes, observe for unsafe transfers, monitor for signs of fatigue, monitor for changes in condition, assess cognitive deficits, keep environment well lit and clutter free, keep call light within reach at all times, remind of safety precautions and limitations and keep bed in low position with brakes on. The facility's Fall Analysis Log documents R1 had a fall on 9/29/22 and the facility did not determine a root cause but documents a new intervention of putting a sign in R1's room. This log documents R1 had a fall on 9/30/22 and the facility did not determine a root cause but documents a new intervention of moving R1 closer to the nurse's station. This log documents R1 had a fall on 11/4/22 and the facility did not determine a root cause and documents new interventions of a scoop mattress and a fall mat placed. This log documents R1 had a fall on 11/7/22 and the facility did not determine a root cause but document a new intervention of a toilet seat riser. These interventions were not documented on the Care Plan provided on 12/5/22 by V1 Administrator in Training. On 12/6/22 at 1:37 PM, V7 and V10 Certified Nursing Assistants (CNAs) stated that they do not remember R1 having any fall interventions in place. V7 stated they would tell R1 to turn R1's call light on when R1 needed help. On 12/7/22 at 10:31 AM, V13 Certified Nursing Assistant stated there were no fall interventions in place for R1. There was no fall mat, no toilet seat riser, no sign in the room, no scoop mattress or floor mat.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 32853 Based on observation, interview and record review the facility failed to prevent cross contamination during wound care for one of four residents (R5) reviewed for wounds in the sample list of nine. Findings include: The facility's Aseptic Wound and Skin Treatment Procedure with a revised date of January 2018 documents, Purpose: To prevent contamination of the wound, protect wound from mechanical injury, to stimulate, restore, and promote circulation and healing, prevent further deterioration of skin tissue, prevent necrosis of deeper body structures, and to promote resident comfort. 14. Clean the wound as ordered. Clean from center outward, never going back over area, which has been cleaned. R5's Physician's Order Sheet (POS) dated 11/1/22 through 11/30/22 documents diagnoses including Skin Picking, Advanced Dementia, Failure to Thrive, Neuropathy and Diabetes. This POS documents a treatment order for the right buttock to apply calcium alginate, a foam bordered dressing and change daily. On 12/6/22 at 1:55 PM, V12 Licensed Practical Nurse (LPN) completed a dressing change for R5 on R5's Right Buttock. V12 washed V12's hands and donned gloves. V12 dumped normal saline on a few 4 inch x (by) 4 inch gauze pads and wiped over the open wound several times over the same area of the wound with the same area of the dampened gauze. V12 changed V12's gloves and applied the calcium alginate and foam dressing. On 12/7/22 at 1:45 PM, V3 Regional Administration confirmed the nurses should follow the policy for preventing cross contamination.