STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	03/02/2022

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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S 000	Initial Comments Annual Licensure and Certification survey	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 300.1210b) 300.1210d)3)6) 300.1220b)2) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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. d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. These Requirements were Not met evidenced by: Based on observation, interview, and record review the facility failed to ensure R3 was not subjected to a physical restraint and assessed for appropriate and necessary use of a physical restraint. As a result R3 sustained a right ankle fracture attempting to get free from a physical restraint. R3 is one of one resident reviewed for accidents on the sample list of 26. Findings include: On 3/1/22 at 11:00 AM, R3 was sitting at a dining room table. R3's wheelchair (wheels) was locked. R3 was pushing down on the wheelchair arms and attempting to stand but could not do so due to chair placement against the table. R3 was	S9999		

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S9999	Continued From page 2	S9999		

also pushing against the table and could not push backwards. R3 sat at this table until after lunch (12:30 PM), R3 continued to push against the table and attempted to stand unsuccessfully. R3 demonstrated no ability to unlock the wheelchair that forced R3 to remain at the table. R3 was identified to have the ability to independently self-propel R3's wheelchair while in the seated position.

R3's radiology report dated 1/31/22 documents a right lateral mallelor (ankle) fracture.

R3's Investigation Final Report dated 2/8/22 documents on 2/1/22, R3 complained of right ankle pain and had bruising to the right ankle. This report documents an x-ray was obtained which showed a right ankle fracture. This report documents V18, R3's Physician determined the fracture was caused from R3 rolling the ankle when attempting to move the wheelchair or when attempting to ambulate.

On 3/2/22 at 10:00 AM, V1 Administrator stated it was determined that R3 rolled the right ankle when attempting to push self up and away from table. V1 stated R3's wheelchair is locked (by staff) so R3 can not move away from the table due to fall precautions. V1 stated R3 will push, rock, and attempt to stand while at the table. V1 stated the physician determined the cause of the fracture was from R3 rolling her ankle when attempting to move away from the table.

R3's current medical record as reviewed on 3/1/22 had no documented evidence of a completed physical restraint assessment or any record related to medical symptoms warranting the use of, or being treated by physically restraining R3, with locked wheelchair wheels.

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S9999	Continued From page 3 (B) (2 of 2) 300.610a) 300.1210b) 300.1210d)3)5) 300.1220b)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal	S9999		

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S9999	Continued From page 4 care needs of the resident. d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3)Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy	S9999		

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S9999	Continued From page 5 These Requirements were Not met evidenced by: Based on observation, interview, and record review the facility failed to implement resident centered interventions to prevent new/worsened pressure ulcers, failed to prevent cross contamination of Stage III and Stage IV pressure ulcers during a residents incotinence care and failed to document weekly wound assessments for five residents (R17,R27,R32,R34, R21) of five residents reviewed for pressure ulcers in a sample list of 26. This failure caused development of new Stage II pressure ulcers for three (R32, R17, R27) the five residents. Findings include: 1. R32's Physician's Order Sheet (POS) for February 1-28th, 2022 includes the following diagnoses: Insulin Dependant Diabetes, Quadriplegia, Legally Blind in Both Eyes." On 3/1/22 at 9:26AM V12, Certified Nurse's Aide (CNA) and V13 Certified Nurse's Aide (CNA) assisted R32 to bed from her wheelchair with a sling type mechanical lift. As R32 was lifted urine poured on the wheel chair and floor. V12 rolled R32 in bed and her slacks were soaked with urine. V12 and V13 did not provide R32 with incontinence care at this time. V12 placed R32's blankets on R32 and both CNA's left the room. On 3/1/22 at 10:00AM when asked if V12 had noticed the urine on R32 V12 stated she had and would provide incontinence care for R32. R32's adult diaper was heavy with foul smelling urine	S9999		

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S9999	Continued From page 6	S9999		

and she was soaked through to the bed sheets. R32 was observed to have two dime size Stage II pressure ulcers to the right and left side of R32's coccyx. V12 stated "I will let the wound nurse know."

On 3/1/22 at 10:30AM V13 stated "I did see the urine dripping on the wheel chair, but (V12) was taking care of (R32) and I thought she would clean (R32)."

On 3/2/22 at 10:15AM R32 stated "I could use a diaper I am wet and dirty." V12 stated she was going to get supplies.

On 3/2/22 at 11:00AM V15, Licensed Practical Nurse (LPN) stated (R32) doesn't have any treatments ordered except barrier cream. I wasn't aware she had any open areas. V15 stated she would "call and get a treatment order." No wound assessment was documented.

On 3/2/22 at 11:05AM V12 returned with V8, Certified Nurse's Aide (CNA) to provide incontinence care for R32. In addition to the stage II pressure ulcers on R32's right and left coccyx R2 also had a Stage II pressure uler to her right gluteal cleft and a pin point Stage II pressure ulcer to her left second toe.

2. R27's Physician's Order Sheet (POS) for February 1-28th 2022 documents the following diagnoses: Diabetes, Left Below the Knee Amputation, and History of Cerebral Vascular Accident. R27's Care Plan last updated 11/16/21 documents R27 is at high risk for pressure ulcers.

On 3/1/22 at 2:00PM R27 stated his "butt hurt". V4, Licensed Practical Nurse (LPN) wound nurse assisted R27 to roll to his side. R27 was

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S9999	Continued From page 7 incontinent of urine and being provided care. R27 had three dime sized pressure ulcers to his left buttock. On 3/1/22 at 2:00PM V4 stated "I work the floor so I don't have time to get all my wound care done. (R27) was healed and now he's open again." 3. R17 Physician's Order Sheet (POS) for February 1-28th 2022 documents the following diagnoses: Multiple Sclerosis, Insulin Dependent Diabetes, Anxiety. R17 Wound Evaluation and Summary dated 2/27/22 documented R17 has a 1. Stage IV pressure ulcer to the right medial ischium full thickness, of greater than 437 days duration 2. A Stage III Pressure Ulcer on his right lower Medial Ishium of greater that 227 day duration. and 3. A shearing wound to the right thigh that is new. The wound physician ordered a calcium alginate dressing covered with an abdominal pad for the Stage III and the Stage IV and house barrier cream to the shearing wound. On 3/1/22 at 11:45AM V12, Certified Nurse's Aide (CNA) removed R17's adult diaper to provide incontinence care. There were dressings in place to the Stage III and StageIV sites. V12 removed the dressings and discarded them. She then used the same wash cloth she had used to clean the rectal area and ran it over the two wounds. She did not notify the nurse to come in and properly cleanse the wound and reapply the ordered dressing. R17 had been laying on, the Yshaped tubing to R17's urinary catheter under his right buttock. There was a new Stage II pressure area in the shape and size of the tubing on R17's right buttock. V12 replaced the adult	S9999		

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S9999	Continued From page 8 diaper over the wounds. On 3/1/22 at 1:30PM R1 stated "The nurse never did come back in and put the bandage on my bottom." On 3/1/22 at 2:00PM V12 stated "I guess I should have left the dressing alone. and let the nurse change it." No wound measurements or assessments for R17 documented from 12/5/21 until 12/30/21. No wound measurements or assessments for R17 documented from 12/30/21 until 1/12/22. No wound measurements or assessments for R17 documented from 1/20/22 until 2/13/22. No wound measurements or assessments for R17 documented from 2/13/22 until 2/27/22. 4. On 2/27/22 R21's physician wound evaluation and management summary documents a 0.5 centimeter by 0.3 centimeter stage two pressure wound of the right buttock with an order for Aloevesta cream to be applied to R21's buttocks three times a day. On 2/28/22 R21's nurse's notes document R21 complaining of bottom pain. R21's treatment administration record dated February 2022 documents skin checks and assessments to be done daily. These checks were not done daily but rather 10 of 28 days. On 2/28/22 at 8:02AM V4 Licensed Practical Nurse/Wound Nurse stated R21 did not have any open areas to the coccyx and no treatment other than barrier cream was being put on R21's coccyx.	S9999		

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S9999	Continued From page 9 On 3/2/22 at 8:15AM V4 Licensed Practical Nurse/Wound Nurse performed pericare on R21 A dime sized open area on the right buttock was covered in thick liquid feces and urine. 5. R34's February 2022 Treatment Administration Record documents an order for daily skin checks and assessments. Skin checks were not performed 8 days in the month of February. On 2/28/22 V4 Licensed Practical Nurse stated that R34 did not have any open areas on R34's bottom. On 3/1/22 at 2:00PM R34 was toileted and a nickel sized stage two pressure ulcer was on R34's sacrum. On 3/1/22 at 1:00PM V4 Licensed Practical Nurse/Wound Nurse stated V21 Physical Therapy Assistant had made V4 LPN aware of R34's wound earlier that day. On 3/2/22 at 8:45AM V4 Licensed Practical Nurse (LPN) stated V4 LPN hadn't had time to perform the treatment and place the dressing on R34 yet and that additional interventions should have been put in place to prevent further skin breakdown. On 3/2/22 at 8:50AM, when asked about not knowing about open areas on the residents, V4 Licensed Practical Nurse/Wound Nurse stated, "Honestly, we just don't have the staff to make sure everything is done the way that it should be." The facility policy revised date 1/18 documents that a wound will be documented on the treatment or wound record and that when a	S9999		

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S9999	Continued From page 10 pressure ulcer is identified, additional interventions must be established and noted on the care plan in an effort to prevent worsening or reoccuring pressure ulcers. Additionally, staff on every shift and as needed will provide skin care. The facility 's policy documents the expectation of preventative skin care through repositioning, careful washing, rinsing, drying and observation. (B)	S9999		