

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058503		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/06/2026	
NAME OF PROVIDER OR SUPPLIER INVERNESS REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 1800 W COLONIAL PARKWAY , INVERNESS, Illinois, 60067			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	
S0000	Initial Comments		S0000			02/27/2026	
	Complaint investigation 2691220/IL2729679						
S9999	Final Observations		S9999			02/27/2026	
	Statement of Licensure Violations:						
	300.610a)						
	300.1010h)						
	300.1210b)						
	300.1210d)3)						
	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 300.1010 Medical Care Policies						
	h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)						
	Section 300.1210 General Requirements for Nursing and Personal Care						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to follow their change in condition policy by not notifying the provider about a resident's urinary retention and being unable to drain urine through catheterization. This failure has caused 1 of 3 residents (R1) in a sample of 3 reviewed for catheter care to be admitted to the intensive care unit (ICU) for aggressive treatment for sepsis secondary to urinary tract infection (UTI). Findings include: R1 is a 77-year-old female originally admitted on 12/26/25, having a slight cognitive impairment as per the Minimum Data Set (MDS) dated 1/1/26. A further review of the MDS also documents that R1 was admitted with an admitting diagnosis including urinary retention and Urinary Tract Infection (UTI). A review of the admission progress note dated 12/26/25 documented that R1 was admitted with a Foley catheter in place. A review of the Physician Order Sheet (POS) and Medication Administration Record (MAR) documented a physician order in place dated 1/21/26 to start voiding trial after removing the Foley catheter and then do post void residual (PVR) every shift for five days. If		S9999				

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S9999	Continued from page 2 PVR is greater than 300 milliliter (ml), straight catheter reinsertion, and third time reinsert foley catheter, and need to follow up with the Urologist. A review of R1's MAR documented that the bladder scan on 1/25/26: morning shift, 450; afternoon shift, 700; and night shift, 654. A review of the administration note dated 1/25/26 at 2:57 PM, V6 (Licensed Practical Nurse / LPN), documented a straight catheter (cath) draining approximately 500 ml of urine. A review of the general note dated 1/25/26 at 8:58 PM documented a bladder scan result of 716 ml urine, and V5 (LPN) straight cathed R1 and drained 650 ml urine out. A review of the administration note dated 1/26/26 at 4:54 AM documented that V6 (LPN) reinserted a 16 French Foley. On 2/5/26 at 6:15 AM, V6 (LPN) stated, "I did the bladder scan for R1 on 1/25/26 night shift, and it was over 300. I reinserted foley, but it was not draining. Another nurse (V8) also tried and was still not draining. After the morning report, I removed the Foley as it was not draining. I know I should have reached out to the urologist or physician on call to let them know that R1 was retaining urine and was unable drain with a catheter." On 2/5/26 at 8:15 AM, V8 (LPN) stated, "V6 was the nurse for R1 on 1/25/36 night shift, and she told me she tried twice to insert foley on R1 as the bladder scan was over 700. She asked for my help, and I inserted foley and it was not draining. V6 told me to leave the Foley in place and wait for a while to see if it drains. I believe the foley was not in place, and that's why it wasn't draining." On 2/5/26 at 8:25 AM, V7 (Morning Nurse/LPN on 1/26/26) stated, "When I got the report from V6 on 1/26/26 morning shift, the foley was still there. I removed it as it wasn't draining, reinserted a new one, and the Foley still wasn't draining. I didn't notify the physician (MD) or nurse practitioner that the indwelling catheter was not draining." On 2/4/26 at 4:45 PM, V10 (hospital social worker) reported that R1 was sent from the urology appointment to the emergency room on 1/28/26 due to low blood pressure and lethargy, diagnosed with urinary retention and sepsis caused by a UTI, and was admitted to the ICU for intensive treatment. On 2/5/26 at 9:10 AM, V2 (Director of Nursing/DON) stated, "If the foley is not draining, it may not have been in place. If multiple staff members couldn't			S9999			

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S9999	Continued from page 3 reinsert the Foley in the right place to drain urine, my staff should notify the physician and follow their order." On 2/4/26 at 3:43 PM, V12 (Nurse Practitioner / NP) stated, "I was on call, and nobody called me to report on R1's urinary retention or inability to drain urine through a Foley catheter. The voiding trial order clearly states to reinsert the Foley a third time if the post-void residual is greater than 300 ml and to follow up with a urologist. Urinary retention can cause discomfort and UTI to residents." The facility presented an acute change of condition policy (dated 1/5/25) statement document: It is the policy of this facility to promptly identify, evaluate, address, and report a resident's change in condition. Procedure: 4. Phone calls to attending or on-call physicians should be made by the nurse who has collected pertinent information, including the resident's current symptoms and status, onset, duration, severity of the change in condition, and available strategies to manage the change of condition in the facility if appropriate. (A)		S9999				