STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146017	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ILLINI HERITAGE REHAB & HC	**1315B CURT DRIVE CHAMPAIGN, IL 61820**

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** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review. the facility failed to follow physician orders [REDACTED]. Findings include: 1. The Physician order [REDACTED]. The After Visit Summary dated 2/19/20 through 3/2/20 documents R1 has [DIAGNOSES REDACTED]. V18's (Wound Physician) Wound Evaluation and Management Summary dated 1/31/20 documents a diabetic wound measuring one centimeter by one centimeter (cm) was found on R1's left distal plantar foot on that date and V18 ordered a treatment of [REDACTED]. The 1/31/20 Wound Evaluation and Management Summary documents R1 also has a diabetic wound of the left lateral ankle measuring 3.5 cm by 2.5 cm which is black necrotic tissue, a diabetic wound of the left heel measuring six cm by five cm which is black necrotic tissue, a wound of the left lateral leg measuring six cm by three cm with a depth of 0.1 cm which is 20% necrotic tissue, a diabetic wound of the right lateral ankle measuring two cm by 1.5 cm which is black necrotic tissue, a diabetic wound of the right heel measuring 1.5 cm by one cm which is necrotic tissue, and a diabetic wound of the right posterior ankle which measures 1.5 cm by one cm which is necrotic tissue. R1's Medical Record does not document monitoring of R1's wounds again until 2/14/20. V18's Wound Evaluation and Management Summary dated 2/14/20 documents R1's left distal plantar foot diabetic wound now measures three cm by three cm and that the wound is 100% devitalized necrotic tissue. V18's Summary documents the wound progress as Deteriorated. The Summary documents an order for [REDACTED]. On 8/13/20 at 12:55 PM ,V3, Wound Nurse Stated V3 could not provide documentation that R1's left distal plantar foot wound treatment was started. On 8/13/20 at 11:50 am, V3 stated wounds are to be monitored weekly. V3 stated R1 was out of the facility at an appointment on 2/7/20 when V18 was at the facility completing wound assessments. V3 stated R1 returned around 12:00 PM on 2/7/20 and staff completing R1's next wound treatments should have measured R1's wounds and documented the information in the nurses notes. 2. The 8/1/20 through 8/31/20 Physician order [REDACTED]. On 8/12/20 at 7:05 AM V3, Wound Nurse completed R2's left medial ankle wound treatment. At that time, a wound with a dark center and red perimeter was present on R2's left medial ankle. V18's (Wound Physician) Wound Evaluation and Management Summary dated 7/10/20 documents R2 has an arterial wound of the left medial ankle which measures two cm by 1.5 cm with a depth of 0.1 cm which is devitalized necrotic tissue. The Note documents the wound progress as no change. The Note documents an order for [REDACTED]. medial ankle wound again until 7/24/20. V18's Wound Evaluation and Management Summary dated 8/7/20 documents an order to continue the treatment of [REDACTED]. The Treatment Administration Records (TAR) dated 7/1/20 through 7/31/20 and 8/1/20 through 8/31/20 document R2's right ankle treatment as (diluted bleach solution) twice daily and petroleum sterile gauze with dry gauze wrap twice daily. The treatment is not initialed as being completed on 7/4/20, 7/5/20, 7/6/20, 7/7/20, 7/10/20, 7/13/20, 7/18/20, 7/19/20, and 7/27/20. On 8/13/20 at 11:50 am V3 stated V3 could not provide documentation of assessment of R2's right ankle wound between 7/10/20 and 7/24/20, and 7/24/20 and 8/7/20. V3 stated on 7/19/20 and 7/30/20, R2 refused to get in bed so V18 could assess R2's wounds. V3 stated the weekly wound assessment should have been completed during the next wound treatment and documented in the nurses notes. On 8/12/20 at 12:26 PM V3 confirmed R2 does not have a current order for diluted bleach solution to be used on R2's left ankle wound. V3 stated V18 discontinued the bleach solution on 6/5/20 and it should have been removed from the TAR. V3 also confirmed the treatment to R2's left ankle is not initialed as being completed on 7/4/20, 7/5/20, 7/6/20, 77/7/20, 7/10/20, 7/13/20, 7/18/20, 7/19/20, and 7/27/20. V3 stated staff should initial the date on the TAR after completing the treatment. The Skin Monitoring Policy revised January 2018 states Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the are must include the following: a. Characteristic 1. Size 2. Shape 3. Depth 4. Odor 5. Color 6. Presence of granulation tissue or necrotic tissue b. Treatment and response to treatment.
F 0686 **Level of harm** - Minimal harm or potential for 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** Based on interview and record review, the facility failed to follow physician wound treatment orders and failed to monitor a pressure sore for one of three residents (R2) reviewed for wound care in the sample of 11 residents. Findings include: The 8/1/20 through 8/31/20 Physician order [REDACTED]. V18 Wound Physician's Note dated 7/10/20 documents R2 has stage three pressure wound on R2's right medial buttock which measures 0.5 centimeters (cm) by 0.2 cm with a depth of 0.1 cm which is 10% granulation tissue and 90% viable tissue. The Note documents instructions for R2 to have a treatment of [REDACTED]. R2's Medical Record does not document monitoring of R2's right buttocks pressure wound again until 7/24/20. V18's Note dated 8/7/20 documents R2's stage three pressure wound measures two cm by 0.2 cm with a depth of 0.5 cm and documents the wound progress as deteriorated. The Note documents an order for [REDACTED]. The treatment is not initialed as being completed on 7/4/20, 7/5/20, 7/6/20, 7/7/20, 7/10/20, 7/13/20, 7/18/20, 7/19/20, and 7/27/20. On 8/13/20 at 11:50 am V3 Wound Nurse stated V3 could not provide documentation of assessment of R2's buttocks pressure wound between 7/10/20 and 7/24/20, and 7/24/20 and 8/7/20. V3 stated on 7/19/20 and 7/30/20, R2 refused to get in bed so V18 could assess R2's wounds. V18 stated the weekly wound assessment should have been completed during the next wound treatment and documented in the nurses notes. On 8/12/20 at 12:26 PM, V3 confirmed R2 does not have a current order for diluted bleach solution, triple antibiotic ointment or collagen to be used on R2's buttock pressure wound. V3 also confirmed the treatment to R2's buttocks pressure sore is not initialed as being completed on 7/4/20, 7/5/20, 7/6/20, 7/7/20, 7/10/20, 7/13/20, 7/18/20, 7/19/20, and 7/27/20. V3 stated staff should initial the date on the TAR after completing the treatment. The Skin Monitoring Policy revised January 2018 states Documentation of the skin abnormality must occur upon identification and at least weekly thereafter until the area is healed. Documentation of the are must include the following: a. Characteristic 1. Size 2. Shape 3. Depth 4. Odor 5. Color 6. Presence of granulation tissue or necrotic tissue b. Treatment and response to treatment.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to safely transfer a resident for one of three residents (R1) reviewed for accidents in the sample of 11 residents. Findings include: The Minimum (MDS) data set [DATE] documents R1 requires extensive assist of two staff members for transfers. The Nurses Note dated 3/7/20 states (R1) being transferred from bedside to w/c (wheelchair), states legs gave out on (R1), res (resident) was lowered to floor onto (R1's) knees per CNA (certified nurses aid). The Fall Analysis Log for March 2020 documents weakness as the root cause of the 3/7/20 fall and documents a new intervention of assist of two staff-staff to use gait belt. V9's (Registered Nurse) Nurses Note dated 3/8/20 states CNA trying to transfer (R1) from w/c to bed after breakfast. (R1) lost balance and lowered down to bed, CNA

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) was holding (R1) and call writer to help. Writer walked in room and take off (R1's) boots and got (R1) up to bed. No injury noted. On 8/17/20 at 3:13 PM , V9 stated on 3/8/20 one CNA was trying to transfer R1 and R1 and the CNA told V9 that R1 lost balance during the transfer. On 8/12/20 at 7:05 am V2, Director of Nurses stated after R1's fall on 3/7/20, R1 should have been transferred with the assistance of two staff members.