STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to complete an accurate quarterly assessment for one of five residents (R12) reviewed for weight loss in the sample list of 15. Findings include: R12's Face Sheet dated 7/30/20 documents R12 has [DIAGNOSES REDACTED]. R12's MDS (Minimum Data Set) dated 4/1/20 documents R12 is cognitively intact, uses limited assistance of one staff person for eating, and has not had a weight gain or loss of 5 % (percent) in one month or 10 % in six months. R12's undated weight log documents R12 weighed 284 lbs (pounds) on 2/24/20 and 267.1 lbs on 3/23/20 (5.9% loss.) R12's Dietary Note dated 4/17/20 8:43 AM by V16 Registered Dietitian documents R12 was reviewed for weight loss at one and three months with a Body Mass Index of 43.6. This note documents weight loss is planned/desired per obesity and [MEDICAL CONDITION] status and R12's diet is therapeutic for weight loss. On 7/30/20 at 4:37 PM V2 Director of Nursing confirmed R12's MDS dated [DATE] does not document R12's significant weight loss of 5 % in one month.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for two of 15 residents (R8, R15) reviewed for care plans on the sample list of 15. Findings Include: 1. R8's undated Face Sheet documents R8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R8's Progress Notes dated 6/7/20 by V49 RN (Registered Nurse) documents R8 was admitted to the facility on [DATE] with a new [MEDICAL CONDITION], and no signs of infection at R8's midabdominal surgical site. R8's Care Plan dated 6/9/20 does not document that R8 has a [MEDICAL CONDITION] or an abdominal surgical wound. On 7/30/20 at 12:15 pm, V2 DON (Director of Nursing) stated R8's care plan should include R8's [MEDICAL CONDITION] and surgical wound. 2. R15's undated Face Sheet documents R15 has a [DIAGNOSES REDACTED]. R15's July 2020 Physician order [REDACTED]. On 7/27/20 at 2:10 pm, R15 was sitting up in a wheelchair in R15's room. R15 had a brace/boot on the right foot/ankle. R15 stated, R15 had a fall at home and broke R15's ankle. I (R15) can't walk and I have to wear this boot at all times. R15's Care Plan dated 6/22/20 does not document that R15 is non-weight bearing due to a fractured ankle and must wear the boot/brace at all times. On 7/30/20 at 12:10 pm, V2 DON (Director of Nursing) confirmed R15's fractured ankle and weight bearing status is not on R15's care plan and should be.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to revise care plans to accurately reflect the current condition of four out of 15 residents (R3, R5, R11, R12) reviewed for care plans on the sample list of 15. Findings Include: 1. R5's undated Face Sheet documents [DIAGNOSES REDACTED]. The facility weight log documents R5's weights as follows: 6/14/20 - 143.4 pounds, and 7/2/20 - 132.4 pounds. That calculates a 7.69% weight loss in less than one month. R5's dietary recommendation for ice cream BID (twice a day) and 2.0 supplement 90 ml (milliliters) TID (three times a day) for low BMI (body mass index) and weight loss dated 7/12/20 by V16 RD (Registered Dietician) was approved by V17 NP (Nurse Practitioner) on 7/16/20. R5's Care Plan dated 5/13/20 documents R5 is at a risk for altered nutrition and fluid status related to stroke with [MEDICAL CONDITION], and dysphagia but has not been revised to reflect R5's actual weight loss or V16's orders. On 7/30/20 at 11:55 am, V2 DON (Director of Nursing) stated R5's actual weight loss should be care planned. 2. R11's undated Face Sheet documents [DIAGNOSES REDACTED]. The facility weight log documents R11's weights as follows: 1/30/20 - 168.8 pounds, 2/1/20 - 186.5 pounds, 4/20/20 - 159 pounds, 5/13/20 - 132.20 pounds, 6/14/20 - 124.2 pounds, 7/2/20 - 118 pounds. That calculates a 30.095% weight loss in less than six months, a 17.61% weight loss in less than one month between April and May 2020, and a 5.344% weight loss between May and June 2020. R11's 7/12/20 dietary recommendation for a frozen nutritional treat TID (three times a day) with meals and fortified cereal, pudding and potatoes each one time daily for poor appetite, low BMI (body mass index), and weight loss was approved by V17 NP (Nurse Practitioner) on 7/16/20. R11's Care Plan dated 5/4/20 documents R11 is at risk for altered nutrition due to Malnutrition but has not been revised to reflect R11's actual weight loss or V16 RD (Registered Dietician) orders. On 7/30/20 at 11:45 am, V2 DON confirmed R11's weight loss and interventions are not care planned and stated, if someone is having weight loss, it should be care planned. 3. R12's Face Sheet dated 7/30/20 documents R12 has [DIAGNOSES REDACTED]. R12's MDS (Minimum Data Set) dated 4/1/20 documents R12 is cognitively intact, uses limited assistance of one staff person for eating, and has not had a weight gain or loss of 5 % (percent) in one month or 10 % in six months. R12's undated weight log documents R12 weighed 284 lbs (pounds) on 2/24/20 and 267.1 lbs on 3/23/20 (5.9% loss.) R12 weighed 255.9 lbs on 7/2/20 and 238.4 (6.8 % loss) on 7/27/20. R12's Dietary Note dated 4/17/20 8:43 AM by V16 Registered Dietitian documents R12 was reviewed for weight loss at one and three months with a Body Mass Index of 43.6. This note documents weight loss is planned/desired per obesity and [MEDICAL CONDITION] status and R12's diet is therapeutic for weight loss. R12's Dietary Note dated 7/29/20 at 6:17 PM by V16 documents follow up per weekly weights suggesting further significant weight loss and appetite decline. This note documents R12's diet has been downgraded to mechanical soft with pureed meat and a request to add a nutritional supplement 120 cc (cubic centimeters) four times daily. R12's Care Plan dated 7/30/20 documents R12 has the potential for significant weight changes due to current medical condition with interventions to notify the physician for any changes of appetite and issues with compliance, obtain weekly weights or as ordered by the physician and to continue working with speech therapy. R12's Care Plan does not document R12's weight loss or interventions prior to 7/30/20. On 7/30/20 at 4:37 PM V2 Director of Nursing stated R12's Care Plan was updated today to reflect R12's weight loss. V2 confirmed R12's Care Plan did not address R12's weight loss prior to 7/30/20. 4. R3's Face Sheet dated 7/30/20 documents R3 admitted to the facility on [DATE] and discharged on [DATE]. This Face Sheet documents R3's [DIAGNOSES REDACTED]. R3's Admission MDS dated [DATE] documents R3 has severe cognitive impairment, uses extensive assistance of two staff for bed mobility, transfers, and toileting, is incontinent of bowel and bladder, and admitted to the facility without and pressure ulcers. R3's Pressure Ulcer Risk assessment dated [DATE] documents a score of 17 indicating R3 is at risk for developing pressure ulcers. R3's Initial Wound Evaluation and Summary by V29 Wound Physician dated 3/11/20 documents R3's Sacral wound as Unstageable due to necrosis (dead tissue) with measurements 9 cm (centimeters) long by 7.5 cm wide by 0.2 cm deep. This summary documents R3 has diabetic wounds to the left lateral ankle measuring 3.5 cm by 2.5 cm by no measurable depth, left lateral heel measuring 2.5 cm by 1.5 cm by no measurable depth, left lateral foot measuring 1.5 cm by 0.5 cm by no measurable depth, right lateral

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

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.

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) ankle measuring 3 cm by 1.5 cm by no measurable depth, and right distal plantar foot measuring 4.5 cm by 3 cm by no measurable depth. This Summary documents recommendations to limit R3's sitting to 60 minutes, use a low air loss mattress, and use heel protectors. R3's Wound Evaluation and Summary by V29 dated 3/18/20 documents R3's Stage 4 Pressure Wound to the sacrum measured 6 cm long by 5.5 cm wide by 1 cm deep. This Summary documents R3 has diabetic wounds to the left lateral ankle measuring 3.5 cm by 2 cm by no measurable depth, left lateral heel measuring 3 cm by 2 cm by no measurable depth, left lateral foot measuring 6 cm by 1.5 cm by no measurable depth, right lateral ankle measuring 3.5 cm by 2.5 cm by no measurable depth, right distal plantar foot measuring 4.5 cm by 2.5 cm by no measurable depth and left proximal medial foot measuring 0.5 cm by 0.5 cm by no measurable depth. R3's Care Plan revised on 3/2/20 documents R3 has the potential for skin alteration or skin breakdown related but not limited to: noncompliance, decreased activity and mobility, incontinence and current medical condition. This Care Plan documents interventions dated 3/2/20 to assist with toileting care needs, pressure reducing mattress, reposition as tolerated, over for skin breakdown with showers and activities of daily living care, and refer to the physician as needed for skin impairment issues. R3's Care Plan has not been updated to reflect R3's Stage 4 Pressure wound to the sacrum or R3's diabetic wounds to R3's feet and ankles or any new interventions since 3/2/20. On 7/30/20 at 4:37 PM V2 DON (Director of Nursing) confirmed R3's Care Plan did not document R3's Stage 4 Pressure Wound to the sacrum, R3's diabetic wounds, or any new interventions for skin impairment since 3/2/20.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and observation, the facility failed to assist with eating/dining for two of three residents (R5, R11) reviewed for Activity of Daily Living assistance on the sample list of 15. 1. R5's undated Face Sheet documents the following Diagnoses: [REDACTED]. R5's MDS (Minimum Data Set) dated 5/1/20 documents R5 requires supervision of one staff for eating. On 7/27/20 at 1:00 pm and 1:22 pm, R5 was lying in bed with eyes closed, head of the bed was elevated 80 degrees. R5's lunch was sitting on the over bed table that was positioned across the top of R5's bed. There were no staff in the room providing assistance or supervision for R5. On 7/27/20 at 1:31 pm, V8 RN (Registered Nurse) entered R5's room to assist R5 with eating. R5 drank 50% of Kool-aid, and ate a few bites of stuffing. On 7/27/20 at 1:37 pm, V7 CNA (Certified Nursing Assistant) stated that R5 is needing more assistance with eating lately. 2. R11's undated Face Sheet documents the following Diagnoses: [REDACTED]. R11's MDS (Minimum Data Set) dated 4/21/20 documents R11 requires extensive assistance of two staff for Bed Mobility, and supervision of one staff for eating. On 7/27/20 at 12:50 pm, R11 was observed lying in R11's bed, with the head of bed elevated 30 degrees, with food covering the front of R11's gown and bedding. R11's lunch tray was on an over bed table, which was positioned across the top of R11's bed. R11 was attempting to feed himself. R11 stated, I (R11) can't sit up. There were no staff in the room assisting R11 with eating, or with proper bed positioning so R11 could feed himself. On 7/27/20 at 1:10 pm, V6 RN (Registered Nurse) stated, R11 should be sitting upright. V6 raised R11's head of the bed to 90 degrees and stated, R11 needs someone to monitor R11 during meals, and assist as needed.
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 interview, and record review, the facility failed to implement physician ordered interventions for a diabetic ulcer, and failed to obtain physician ordered laboratory values for two of 15 residents (R6, R7) reviewed for physician orders [REDACTED]. Findings include: 1. R6's Face Sheet dated 7/30/20 documents R6 admitted to the facility on [DATE] and discharged on [DATE]. This Face Sheet documents R6's [DIAGNOSES REDACTED]. R6's Admission MDS dated [DATE] documents R6 has severe cognitive impairment, uses extensive assistance of two staff for bed mobility, transfers, and toileting, is incontinent of bowel and bladder, and admitted to the facility with no ulcers or wounds. R6's Care Plan revised on 5/14/20 documents R6 has pressure wounds and diabetic wounds with interventions dated 4/16/20 to elevate heels off the bed by using pillows and heel protectors on while in bed. R6's Initial Wound Evaluation and Management Summary by V29 Wound Physician dated 4/8/20 documents R6 has a left heel diabetic wound that measured 8.5 cm (centimeters) long by 8 cm wide by no measurable depth and a left distal medial foot diabetic wound that measured 3 cm by 1.5 cm by no measurable depth. This summary documents a recommendation by V29 for R6 to wear heel protectors when in bed. R6's Wound Evaluation and Management Summary by V29 dated 4/15/20 documents R6's left heel wound measured 8.5 cm by 8 cm by no measurable depth and R6's left distal medial foot wound measured 3 cm by 1 cm by no measurable depth. This summary documents a recommendation for R6 to wear heel protectors when in bed. There is no documentation in R6's medical record that V29's recommendation for heel protectors was implemented prior to 4/16/20 (8 days after the recommendation was made.) On 7/30/20 at 4:37 PM V2 Director of Nursing stated V2 has no documentation that R6 was wearing heel protectors prior to 4/16/20. V2 stated V2 would expect physician orders [REDACTED]. 2. R7's undated Face Sheet documents R7 was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R7's NP (Nurse Practitioner) Notes dated 4/17/20 by V17 NP documents R7 is a new admission to the facility after a hospital stay for frequent falls and weakness. R7 has a history [MEDICAL CONDITION] with mild left residual; also has some dementia, CKD, and many other comorbidities. R7 was found to have increased [MEDICAL CONDITION] to bilateral lower extremities, in which R7 takes [MEDICATION NAME] (diuretic) routinely for. R7's BNP (Brain Natriuretic Peptide) was elevated on exam. Complete a CBC (Complete Blood Count) and a BMP (Basic Metabolic Panel) in one week. R7's medical record contained a CBC and BMP dated 4/30/20, two weeks after it was ordered instead of one week. R7's NP Notes dated 5/20/20 by V17 documents R7 is seen today due to a reported poor appetite lately. R7 stated he just doesn't feel like eating and a review of weights document R7 was 184 pounds upon admission and currently weighs 147 pounds, {a 37 pound weight loss in 1 month}. CBC and CMP (Comprehensive Metabolic Panel) ordered. R7's medical record does not contain results of a CBC and CMP, nor does it contain documentation that these laboratory tests were ever drawn. On 7/30/20 at 12:35 pm, V2 DON (Director of Nursing) stated V2 doesn't know why R7's CBC an BMP were not completed as ordered because the laboratory comes to the facility Monday through Friday, and will come in on the weekends also if the laboratory test is called in STAT (right now). V2 also confirmed that R7's CBC and CMP are not in R7's medical record and appears to have not been completed at all.
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 notify the physician of a worsening pressure ulcer, implement physician ordered pressure relieving interventions, obtain a wound culture, and identify and measure a pressure ulcer weekly for three of five residents (R2, R3, R10) reviewed for pressure ulcers in the sample list of 15. Findings include: 1. R10's Face Sheet dated 7/30/20 documents R10 has [DIAGNOSES REDACTED]. R10's MDS (Minimum Data Set) dated 4/13/20 documents R10 has long term memory loss, uses extensive assistance of two for bed mobility and is dependent on two staff for toileting. This MDS documents R10 has no pressure ulcers. R10's Care Plan revised on 7/9/20 documents R10 is at risk for pressure ulcers related to possible friction and shear during transfers, incontinence, immobility, and inadequate nutrition. R10's Care Plan revised on 4/21/20 documents R10 is at risk for skin breakdown and has a history of an open area to R10's neck under the [MEDICAL CONDITION] collar. This Care Plan documents interventions to assess and monitor R10's skin with every position change. R10's Pressure Ulcer Risk assessment dated [DATE] documents a score of 12 indicating R10 is at high risk for developing pressure ulcers. There are no documented Pressure Ulcer Risk Assessments in R10's medical record since 10/12/19. R10's Physician order [REDACTED]. R10's Physician order [REDACTED]. to the left neck has re-opened, and treatment orders were obtained for calcium alginate and foam dressing to be applied three times weekly. R10's Wound Evaluation and Management Summary by V29 Wound Physician dated 3/11/20 documents R10's shear wound to the left lateral neck is resolved. R10's Wound Evaluation and Management Summary by V29 dated 6/3/20 documents R10's shear wound to the left lateral neck measures 4.5 cm (centimeters) long by 1 cm wide by 0.1 cm deep. There are no documented measurements of R10's left lateral neck shear wound after being identified on 4/9/20 until R10 was seen by V29 on 6/3/20. On 7/30/20 at 12:40 PM V34 Assistant Director of Nursing stated V34 was the facility's wound nurse until a couple weeks ago. V34 stated V34 did

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) not consider R10's shear wound to be a pressure ulcer. V34 stated there are no measurements of R34's shear wound from 4/9/20 until R10 was seen by V29 on 6/3/20. V34 stated Pressure Ulcer Risk Assessments are to be completed upon admission and then quarterly and pressure ulcers are to be measured weekly. On 7/30/20 at 4:37 PM V2 Director of Nursing confirmed there are no documented measurements for R10's left neck shear wound between 4/9-6/2/20 and R10's last documented Pressure Ulcer Risk Assessment was completed on 10/12/19. 2. R3's Face Sheet dated 7/30/20 documents R3 admitted to the facility on [DATE] and discharged on [DATE]. This Face Sheet documents R3's [DIAGNOSES REDACTED]. R3's Admission MDS dated [DATE] documents R3 has severe cognitive impairment, uses extensive assistance of two staff for bed mobility, transfers, and toileting, is incontinent of bowel and bladder, and admitted to the facility without and pressure ulcers. R3's Care Plan revised on 3/2/20 documents R3 has the potential for skin alteration or skin breakdown related but not limited to: noncompliance, decreased activity and mobility, incontinence and current medical condition. R3's Pressure Ulcer Risk assessment dated [DATE] documents a score of 17 indicating R3 is at risk for developing pressure ulcers. R3's Initial Wound Evaluation and Summary by V29 Wound Physician dated 3/11/20 documents R3's Sacral wound as unstageable due to necrosis (dead tissue) with measurements 9 cm (centimeters) long by 7.5 cm wide by 0.2 cm deep. This Summary documents recommendations to limit R3's sitting to 60 minutes and to use a low air loss mattress. R3's Wound Evaluation and Summary by V29 dated 3/18/20 documents R3's Stage 4 Pressure Wound to the sacrum measured 6 cm long by 5.5 cm wide by 1 cm deep and the wound was 40 percent necrotic. R3's physician's orders [REDACTED]. There is no documentation in R3's Medical Record that V29's recommendation to limit R3's sitting to 60 minutes was implemented or that an air mattress was applied to R3's bed prior to 3/16/20 (five days after recommended by V29.) R3's Progress Note dated 3/16/20 11:13 AM by V17 Nurse Practitioner documents R3 was seen due to a fever ranging from 99.0 to 100.9 degrees Fahrenheit. This note documents R3 has a coccyx wound that was debrided by V29 last week and documents an order to obtain a wound culture. R3's Progress Note dated 3/16/20 2:03 PM by V8 Registered Nurse documents R3's urine sample and wound culture were obtained and the laboratory would pick up tomorrow. R3's Progress Note dated 3/20/20 10:59 PM by V51 Licensed Practical Nurse documents R3's coccyx wound culture was collected. R3's Coccyx Wound Culture dated 3/19/20 documents R3's Wound Culture collected on 3/17/20 was not labeled and will need to be recollected. R3's Coccyx Wound Culture dated 3/26/20 documents R3's wound culture was obtained on 3/21/20. This culture documents R3's wound had heavy growth of Escherichia Coli (bacteria) and moderate growth of [MEDICATION NAME] Faecalis. On 7/30/20 at 4:37 PM V2 DON (Director of Nursing) confirmed there is no documentation in R3's medical record that V29's recommendation to limit R3's sitting was implemented or that R3's air mattress was applied prior to 3/16/20. V2 confirmed R3's Wound Culture was not completed until 3/20/20. V2 stated V2 would expect physician's orders [REDACTED]. R2's Face Sheet dated 7/30/20 documents R2 admitted to the facility on [DATE] and discharged on [DATE]. This Face Sheet documents R2 has [DIAGNOSES REDACTED]. R2's MDS dated [DATE] documents R2 has short term and long term memory loss, uses extensive assistance of two staff for bed mobility and toileting, is totally dependent upon two staff for transfers, is always incontinent of bowel and bladder, and has one stage 3 Pressure Ulcer. R2's Pressure Ulcer Risk assessment dated [DATE] documents a score of 9 indicating R2 is at very high risk of developing pressure ulcers. R2's Care Plan revised on 1/8/20 documents R2 has a pressure ulcer to the sacrum, right ischium, and left lateral leg. R2's Wound Evaluation and Management Summary by V29 Wound Physician dated 11/20/19 documents R2's Sacrum Stage 3 Pressure Wound measured 3 cm long by 2 cm wide by 0.1 cm deep, Right Upper Sacrum Shear Wound measured 0.3 cm by 0.3 cm by 1.8 cm with undermining of 2.8 cm at 12 o'clock, Right Ischium Stage 3 Pressure Wound measured 0.3 cm by 0.2 cm by 0.1 cm, Left Lateral Ischium Stage 3 Pressure Wound measured 1 cm by 0.5 cm by 0.1 cm, and Right Lateral Foot Stage 3 Pressure Wound measured 0.5 cm by 0.4 cm by 0.1 cm. R2's Wound Evaluation and Management Summary by V29 dated 11/27/19 documents R2's Sacrum Stage 3 Pressure Wound measured 3 cm by 2 cm by 0.1 cm, Right Sacrum Shear Wound measured 0.2 cm by 0.2 cm by 2 cm with 3 cm with undermining of 3 cm at 12 o'clock, Right Ischium Stage 3 Pressure Wound measured 0.3 cm by 0.2 cm by no measurable depth, Left Ischium Stage 3 Pressure Wound measured 1 cm by 0.5 cm by 0.1 cm, and Right Lateral Foot Stage 3 Pressure Wound measured 0.5 cm by 0.2 cm by 0.1 cm. R2's Nursing Note by V50 Licensed Practical Nurse dated 11/23/19 at 3:38 AM documents Foul odor and yellowish discharge noted in undermining; dressing change done. Resident (R2) tolerated well procedure. I (V50) will report next shift to keep monitoring (R2's) wounds. There is no documentation that V29 was notified of the odor or yellow discharge noted from R2's wound. On 7/30/20 at 12:40 PM V34 Assistant Director of Nursing stated V34 was the facility's Wound Nurse until a couple weeks ago. V34 stated that any changes in a wound such as odor, excessive drainage, change in drainage, or a decline in measurements should be reported to V29 Wound Physician. On 7/30/20 at 4:37 PM V2 Director of Nursing confirmed there is no documentation in R2's medical record that V29 was notified of a decline in R2's wound on 11/23/19. The facility's Prevention of Pressure Ulcers Policy with a revision date of November 2015 documents a pressure ulcer risk assessment form will be used to assess resident's skin and pressure ulcer risk. This policy documents preventative measures include reducing friction and shear by lifting the resident rather than dragging, determine the need of a special mattress if a resident is in bed and has a sacral/buttock wound, and changing the resident's position at least every 2 hours or more frequently if needed when the resident is seated in a chair. This policy documents to routinely assess the resident's skin, document the condition and any signs or symptoms of irritation or breakdown, and notify the physician with any changes in the resident's medical condition. This policy documents a healed pressure ulcer is a risk factor for developing pressure ulcers and stage 3 and 4 pressure ulcers are more likely to have recurrent breakdown.
F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to trim toenails for three of four dependent residents (R4, R9, R11) reviewed for foot care on the sample list of 15. Findings Include: The facility Care of Fingernails/Toenails Procedure dated 10/2010 documents nail care includes cleaning and regular triming of the nails, stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or to thick to cut with ease. 1. R4's undated Face Sheet documents R4 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. On 7/27/20 at 9:40 am, R4 was sitting up in a wheelchair in R4's room. R4 stated R4 has been at the facility for almost four months and that R4's toenails have never been cut, and are extremely long and uncomfortable. R4 stated R4 normally has a Podiatrist cut R4's nails but hasn't been able to see a Podiatrist since coming into the facility, so R4 would be willing to allow a nurse to trim them. R4's right foot toenails are all short and thick, and don't stick out past the end of the toes. R4 stated, that is because they snapped and broke off due to their length. Check out the other foot. R4's left foot toenails are thick and stick out past the end of the toe by 1/4-1/2 inch. On 7/27/20 at 11:15 am, V8 RN (Registered Nurse) stated the facility has a podiatrist that comes to the facility however nurses are allowed to cut toenails of Diabetic residents if needed, but CNA's (Certified Nursing Assistant's) are not allowed to. On 7/27/20 at 11:30 am, V1 Administrator stated the Podiatrist is suppose to come to the facility monthly however if a diabetic needs their nails cut, the nurses can cut their toenails unless there is an order to specifically not cut them. R4's July POS (Physician order [REDACTED]. The facility provided a list of all residents seen by V19 Podiatrist Since April 2020 and R4 had not been seen. On 7/30/20 at 10:42 am, V32 Scheduler stated V32 is going to start making a list of all the residents that need seen by V19 monthly but stated, none of the nurses reported to me that (R4) needed to be seen. 2. R11's undated Face Sheet documents the following Diagnoses: [REDACTED]. R11's MDS (Minimum Data Set) dated 4/21/20 documents R11 requires extensive assistance with personal hygiene. On 7/27/20 at 11:10 am, R11 was lying in bed. R11's toenails on the left foot were thick and sticking over the end of the toes by a 1/4 of an inch. On 7/27/20 at 11:15 am, V8 RN (Registered Nurse) stated the facility has a podiatrist that comes to the facility however nurses are allowed to cut toenails of Diabetic residents if needed, but the CNA's (Certified Nursing Assistant's) are not allowed to. On 7/27/20 at 11:30 am, V1 Administrator stated the Podiatrist is suppose to come to the facility monthly however if a diabetic(person with Diabetes) needs their nails cut, the nurses can cut their toenails unless there is an order to specifically not cut them. R11's July POS (Physician order [REDACTED]. 3. R9's Face Sheet dated 7/30/20 documents R9 admitted to the facility on [DATE] and discharged on [DATE]. This Face Sheet documents R9 has a [DIAGNOSES REDACTED]. R9's Minimum (MDS) data set [DATE] documents R9 has moderately impaired cognition and uses extensive assistance of two staff for personal hygiene. R9's Care Plan revised on 4/23/20 documents R9 has a self care deficit and requires assistance with activities of daily living and documents an intervention to assist R9 with personal hygiene daily and as needed. R9's Physician order [REDACTED]. R9's Grievance Form dated 6/27/20 documents a concern made by V47 (R9's Power of Attorney) that R9's nails are long and need cut. This Grievance Form documents a response that R9 was placed on the Podiatry List. R9's Shower Sheet dated 7/1/20 documents R9's toenails need to be cut.

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	145439	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0687 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) There is no documentation in R9's medical record that R9's toenails were cut. The facility provided Podiatry Lists for April - July 2020. There is no documentation that R9 was treated by a Podiatrist between April and July 2020. R9's Hospital History and Physical dated 7/6/20 at 4:05 PM documents an assessment/plan under Diabetes Mellitus to consult podiatry for diabetic foot assessment and care. On 7/30/20 at 9:30 AM V25 Licensed Practical Nurse stated the Certified Nursing Assistants do not cut toenails of diabetic residents, it is the responsibility of the nurse or V19 Podiatrist. V25 stated V25 had made a request for V32 Scheduler to add R9 to the Podiatry List due to R9's toe nails needing trimmed. V25 stated V32 did not have the list accurate and R9 was not seen by V19. On 7/30/20 at 10:45 AM V32 Scheduler stated V32 took over scheduling podiatry visits in February 2020. V32 stated V32 does not recall R9 being on the podiatry list. On 7/27/20 at 11:30 AM V1 Administrator stated a Podiatrist makes monthly visits to the facility. V1 stated the nurses can cut diabetic resident's toenails, unless there is an order not to cut them. On 7/30/20 at 10:40 AM V2 Director of Nursing stated R9 was not seen by V19 Podiatrist. V2 stated R9 was added to the July Podiatry List, but R9 discharged from the facility prior to V19's scheduled visit.
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** Failures at this level required more than one deficient statement A. Based on observation, interview, and record review, the facility failed to provide supervision with dining for one of three residents (R11) at risk for aspiration reviewed for weight loss on the sample list of 15. B. Based on interview, and record review, the facility failed to assess a residents fall risk at the time of admission and failed to implement post fall interventions for two of five residents (R3, R5) reviewed for falls on the sample list of 15. Findings Include: a. R11's undated Face Sheet documents the following Diagnoses: [REDACTED]. R11's MDS (Minimum Data Set) dated 4/21/20 documents R11 requires extensive assistance of two staff for Bed Mobility, and supervision of one staff for eating. R11's ST (Speech Therapy) Notes dated 7/17/20 by V18 ST documents R11 is an aspiration risk and needs to be positioned at a 90 degree angle during oral intake as well as for 20 minutes after intake. R11's Care Plan dated 5/4/20 documents R11 is at risk for altered nutrition due to a [DIAGNOSES REDACTED]. On 7/27/20 at 12:50 pm, R11 was observed lying in R11's bed, with the head of bed elevated 30 degrees, with food covering the front of R11's gown and bedding. R11's lunch tray was on an over bed table, which was positioned across the top of R11's bed. R11 was attempting to feed himself. R11 stated, I (R11) can't sit up. R11's undated meal tray card documents, Aspiration Precaution. There were no staff in the room assisting R11 with eating, or with proper bed positioning so R11 could feed himself. On 7/27/20 at 1:10 pm, V6 RN (Registered Nurse) stated, R11 should be sitting upright. V6 raised R11's head of the bed to 90 degrees and stated, R11 needs someone to monitor R11 during meals, and assist as needed. b1. R5's Fall Risk assessment dated [DATE] and 4/4/20 both document R5 as a high fall risk. The facility Fall Log dated 7/27/20 documents R5 had a fall from R5's wheelchair on 3/22/20. R5's Accident Event dated 3/22/20 documents R5 fell from R5's wheelchair while reaching for an object on R5's bed. The post fall intervention was OT (Occupational Therapy) to evaluate R5's wheelchair for safety. R5's OT evaluation dated 4/21/20 {one month after fall} documents reason for referral: patient (R5) has had recent fall sliding out of (R5's) wheelchair. On 7/30/20 at 9:45 am, V43 Therapy Director, confirmed R5 was not evaluated by OT until 4/21/20 and stated V43 did not know why the evaluation was completed so long after R5's fall. V43 stated evaluations are normally completed in a couple days of the request. On 7/30/20 at 11:55 am, V2 DON (Director of Nursing) stated V2 isn't sure why R5 wasn't evaluated by OT until a month after R5's fall. b2. R3's Admission Minimum (MDS) data set [DATE] documents R3 has severe cognitive impairment, and uses extensive assistance of two staff for bed mobility, transfers, locomotion and toileting. R3's Care Plan revised on 3/2/20 documents R3 can potentially have a fall due to being in a new environment, medications, and current medical condition. This Care Plan documents an intervention dated 3/2/20 to use a full mechanical lift with assistance of two staff for transfers. R3's Fall Risk assessment dated [DATE] documents R3 as having no falls within the past 6 months and R6 as being completely immobile. This assessment documents R3 is at low risk for falls. There are no other documented Fall Risk Assessments in R3's medical record. R3's Nursing Note dated 3/21/20 at 5:02 PM by V26 Registered Nurse documents R3 was found lying on R3's right side on the floor in R3's room. This note documents R3 had a bump to the right forehead measuring 8 cm (centimeters) by 8 cm and a bruise to the right hand/thumb measuring 7 cm by 6 cm. This note documents R3 was transferred to the local emergency room for evaluation. On 7/30/20 at 4:37 PM V2 Director of Nursing stated Fall Risk Assessments are to be completed upon admission, quarterly, and post fall. V2 confirmed R3 did not have a Fall Risk Assessment completed upon admission. The facility's Fall Prevention Program with a revision date of November 2015 documents the program should include measures that determine the individual needs of each resident by assessing for the risk of falls and implementation of appropriate interventions. This policy documents to complete a fall risk assessment to identify if the resident is a high risk for falls. This policy documents falls are investigated, the root cause is identified, interventions are implemented as appropriate, and the fall prevention care plan should be updated.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, an record review, the facility failed to ensure therapeutic diets and supplements were provided as ordered to prevent weight loss for four of five residents (R2, R5, R11, R12) reviewed for weight loss on the sample list of 15. Findings Include: 1. The facility ongoing weight log dated 7/27/20 documents R5's weight as 143.4 pounds on 6/14/20 and 132.4 pounds on 7/2/20. This is a calculated weight loss of 7.69% in less than one month. R5's RD (Registered Dietician) Notes dated 7/12/20 by V16 Dietician documents R5 has had a 7.7% weight loss in the past month with a BMI (Body Mass Index) of 20.7. R5's appetite is generally good but will recommend ice cream twice a day, 2.0 supplement 90 ml (milliliters) TID (three times a day) to provide 540 kcals (kilocalories) as well as 25 g (grams) of protein. R5's Dietary Recommendation for the 90 ml of 2.0 supplement TID and ice cream twice a day was approved and ordered by V17 NP (Nurse Practitioner) on 7/16/20. On 7/27/20 at 1:00 pm, R5 was sitting up in bed with eyes closed, with R5's lunch tray on the over bed table. R5's undated tray card documents R5 is to receive milk and ice cream at lunch. R5's tray did not contain ice cream, milk or the ordered 2.0 supplement. On 7/27/20 at 1:25 pm, V11 Dietary Manager confirmed R5's dietary recommendations have been processed due to R5's weight loss and stated, R5 should have received both the milk and ice cream, the CNA's (Certified Nursing Assistant's) would have put those on the trays because the milk is on the drink cart that is sent to the floor and the ice cream is kept in the freezer on the floor. The CNA's just didn't read the card to see what else needed to be given besides what was sent up on the tray. 2. The facility weight log dated 7/27/20 documents R11's weights as 168.8 pounds on 1/30/20, 168.5 pounds on 2/1/20, 159 pounds on 4/20/20, 131.2 pounds on 5/3/20, 124.8 pounds on 6/14/20 and 118 pounds on 7/2/20. This is a calculated weight loss of 30.1% in less than six months, a 17.61% weight loss between April and May 2020, and a 5.34% weight loss between May and June 2020. R11's RD (Registered Dietician) Notes dated 7/12/20 by V16 Dietician documents R11's BMI (Body Mass Index) is down to 15.6 and appetite has been fair to poor. V16 documents 2.0 supplement recently discontinued due to R11's refusal but continues with the magic cup daily. V16 recommends a magic cup TID (three times a day), fortified foods TID, and an evaluation for a feeding tube. R11's Dietary Recommendation for magic cup TID with meals, and fortified cereal/pudding/potatoes one each daily was approved and ordered by V17 NP (Nurse Practitioner) on 7/16/20. On 7/27/20 at 12:50 pm, R11 was lying down in bed with R11's lunch tray on the over bed table. R11's undated meal tray card documents R11 is to receive a frozen nutritional treat and fortified food/cereal, mashed potatoes or pudding for lunch. R11's tray did not contain the fortified food or frozen nutritional treat. On 7/27/20 at 1:15 pm, V11 Dietary Manager confirmed R11 is to get fortified foods and a frozen nutritional supplement. V11 stated fortified mashed potatoes should have been sent on R11's tray and has no idea why it wasn't. At 1:18 pm, V11 asked V15 Dietary Server about why the frozen treat nutritional treat was not sent on R11's tray and V15 replied there was none available today. 3. R2's Face Sheet dated 7/30/20 documents R2's [DIAGNOSES REDACTED]. (Minimum Data Set) dated 1/2/20 documents R2 has short term and long term memory loss and uses extensive assistance of one staff person for eating. This MDS documents R2 has not had a significant weight loss or gain in the past 6 months or 1 month. R2's Care Plan revised on 12/31/19 documents R3 has weight loss, decreased oral intake, and family refusal of feeding tube with interventions for R3 to be reviewed by

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) the Registered Dietitian as needed. R2's Care Plan revised on 12/23/19 documents R2 has the potential for aspiration or choking with interventions to assist R2 during meals and notify the physician for any changes in R2's swallowing activity or function. R2's undated Weight Log documents R2 weighed 97 lbs (pounds) on 12/16/19, 86.4 lbs (a 10.9 percent loss) on 1/9/20, 92 lbs on 2/17/20 and 87.2 lbs (5.2 percent loss) on 2/24/20. There is no documentation in R2's Medical Record that V16 Registered Dietitian or V52 Physician were notified of R2's significant weight loss noted on 1/9/20 or 2/24/20. On 7/29/20 at 2:32 PM V16 stated V16 expects to be notified of a significant weight loss and confirmed V16 was not notified of R2's weight loss on 1/9/20 or 2/24/20. On 7/29/20 at 1:44 PM V2 DON (Director of Nursing) stated a significant weight loss of 5 % (percent) in one month, 7.5 % in 3 months or 10 % in 6 months should be reported to the physician and V16 Registered Dietitian. V2 confirmed there is no documentation that V16 or V52 were notified of R2's significant weight loss on 1/9/20 or 2/24/20. 4. R12's Face Sheet dated 7/30/20 documents R12 has [DIAGNOSES REDACTED]. R12's MDS dated [DATE] documents R12 is cognitively intact, uses limited assistance of one staff person for eating, and has not had a weight gain or loss of 5 % in one month or 10 % in six months. R12's Care Plan revised on 5/5/20 documents R12 requires a therapeutic diet with an intervention dated 12/16/16 to obtain weights per facility protocol and notify the physician and family of significant weight changes and 6/17/15 to obtain dietary consult and follow recommendations. R12's undated weight log documents R12 weighed 255.9 lbs on 7/2/20 and 238.4 (6.8 % loss) on 7/27/20. There is no documentation in R12's Medical Record that V16 Registered Dietitian or V52 Physician were notified of R12's significant weight loss on 7/2/20 and 7/27/20. R12's Dietary Note dated 7/12/20 8:04 PM by V16 documents R12 was reviewed for weight loss of 13.8 % in 6 months. There is no documentation that V16 was notified of R12's significant weight loss on 7/2/20 prior to 7/12/20. On 7/29/20 at 2:32 PM V16 stated V16 reviweed R12 for a significant weight loss on 7/12/20. V16 stated V16 was not aware of R12's additional significant weight loss on 7/27/20. V16 stated V16 expects to be notified when a resident has a significant weight loss. R12's Dietary Note dated 7/29/20 at 6:17 PM by V16 documents follow up per weekly weights suggesting further significant weight loss and appetite decline. This note documents R12's diet has been downgraded to mechanical soft with pureed meat and a request to add a nutritional supplement 120 cc (cubic centimeters) four times daily. On 7/29/20 at 1:44 PM V2 DON stated a significant weight loss of 5 % in one month, 7.5 % in 3 months or 10 % in 6 months should be reported to the physician and V16 Registered Dietitian. V2 confirmed there is no documentation that V16 or V52 were notified of R12's significant weight loss on 7/2/20 until 7/12/20, and significant weight loss on 7/27/20 until 7/29/20. The facility's Weight Assessment and Intervention policy with a revision date of September 2008 documents The multidisciplinary team will strive to prevent, monitor and intervene for undesirable weight loss for our residents. This policy documents 3. Any weight change of 5 % (percent) or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. This policy documents a significant weight loss as a 5 % loss in one month, 7.5 % loss in three months, and a 10% loss in 6 months. The facility's Change in a Resident's Condition or Status policy with a revision date of December 2016 documents the facility will notify the resident's Physician or Practitioner of a significant change in the resident's physical/emotional/mental condition. This policy documents a significant change in condition as a decline or improvement in the resident's status that will not normally resolve itself without interventions.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to document tube feeding administration amounts, administer gastrostomy tube dressing changes as ordered, and notify the physician and dietitian of a significant weight loss for two of two residents (R10, R13) reviewed for tube feedings in the sample list of 15. Findings include: 1. R10's Face Sheet dated 7/30/20 documents R10 has [DIAGNOSES REDACTED]. R10's MDS (Minimum Data Set) dated 4/13/20 documents R10 has long term memory loss, is dependent upon staff for eating, and 51 percent or more of R10's total calories is through tube feeding. R10's Care Plan revised on 4/21/20 documents R10 is at risk for alteration in nutrition status related to NPO (Nothing By Mouth) status and gastrostomy tube feeding. This Care Plan documents an intervention dated 3/9/16 Provide tube feedings as ordered. See MAR (Medication Administration Record.) R10's Physician order [REDACTED]. R10's MARs (Medication Administration Records) dated 5/1-5/30/20, 6/1-6/30/20 and 7/1-7/30/20 document R10's high protein 1.2 calorie formula begins at 2:00 PM and ends at 8:00 PM daily. There is no documented total amount of the high protein 1.2 calorie formula administered daily in R10's medical record. R10's undated Weight Report documents R10's weight on 6/14/20 as 168 pounds and 7/2/20 159.6 pounds (a 5 percent loss.) There are no documented weights after 7/2/20. R10's Progress Note dated 7/24/20 1:16 PM by V16 Registered Dietitian documents V16 reviewed tube feeding nutrition and caloric needs and R10's tube feeding meets 79 percent of R10's estimated kilocalorie needs. This note documents R10's overall weight has been stable over the past 6 months. There is no documentation that V52 Physician or V16 were notified of R10's significant weight loss on 7/2/20. On 7/27/20 at 10:03 AM R10 was lying in bed. R10 had a gastrostomy tube and a bottle of high protein 1.2 calorie formula was attached to a tube feeding pump in R10's room. On 7/29/20 at 1:44 PM V2 DON (Director of Nursing) stated a significant weight loss of 5 percent in one month, 7.5 percent in 3 months or 10 percent in 6 months should be reported to the physician and V16 Registered Dietitian. V2 stated tube feeding administration volumes should be recorded on the MAR, and should be in addition to the on/off times of the feedings. On 7/29/20 at 2:32 PM V16 Registered Dietitian stated V16 would expect to be notified of a significant weight loss. V16 stated if V16 had been notified of R10's significant weight loss, V16 would have recommended the facility reweigh R10. On 7/30/20 at 4:37 PM V2 DON confirmed there is no documentation in R10's medical record of tube feeding volumes administered for May, June, July 2020. V2 confirmed there is no documentation that V52 Physician and V16 Registered Dietitian were notified of R10's significant weight loss on 7/2/20. 2. R13's MDS dated [DATE] documents R13 is severely impaired with cognition and has a gastostomy tube feeding. R13's Care Plan revised on 4/23/20 documents R13 has a gastrostomy tube with tube feedings. R13's Physician order [REDACTED]. R13's TAR dated 7/1-7/30/20 documents R13's gastrostomy site treatment was not administered by V49 Registered Nurse on 7/22, 7/23, 7/24, 7/26, and 7/27/20 during the 3:30 PM - 11:30 PM shift. There is no documentation in R13's medical record why R13's gastrostomy site treatments were not administered as ordered. On 7/30/20 at 4:37 PM V2 DON stated R13 refuses R13's treatments at times. V2 confirmed there is no documentation why R13's gastrostomy site treatments were not administered on 7/22-7/24, 7/26, and 7/27/20. V2 stated V2 would expect physician orders [REDACTED]. This policy documents Preventing Skin Breakdown: 1. Keep the skin around exit site clean, dry and lubricated (as necessary.) The facility's Weight Assessment and Intervention policy with a revision date of September 2008 documents The multidisciplinary team will strive to prevent, monitor and intervene for undesirable weight loss for our residents. This policy documents 3. Any weight change of 5 % (percent) or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. This policy documents a significant weight loss as a 5 % loss in one month, 7.5 % loss in three months, and a 10% loss in 6 months. The facility's Change in a Resident's Condition or Status policy with a revision date of December 2016 documents the facility will notify the resident's Physician or Practitioner of a significant change in the resident's physical/emotional /mental condition. This policy documents a significant change in condition as a decline or improvement in the resident's status that will not normally resolve itself without interventions.