

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2021
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL ROAD URBANA, IL 61802
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S 000	Initial Comments Complaint Investigation 2162198/IL132333	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) 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	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	<p>Continued From page 1</p> <p>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.</p> <p>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:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to assess a new pressure ulcer, transcribe and implement orders for a pressure ulcer treatment, failed to prevent new pressure ulcers from developing, and failed to assess for and implement nutritional interventions to promote healing of pressure ulcers for two of three residents (R1 and R2) reviewed for pressure ulcers on the sample list of 13. These failures resulted in R2 developing multiple stage two pressure ulcers and R1</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>developing an avoidable stage two pressure ulcer.</p> <p>Findings include:</p> <p>The facility's undated Skin Care Guidelines document the facility will ensure that all residents will receive appropriate assessment and care to prevent and treat pressure injuries and other wounds. The facility will maintain an organized and holistic approach to wound prevention and management by including the following aspects: completion of risk assessments, implementation of preventative measures, management of tissue loads, assessment of the skin and wound, support for the healing of all types of wounds, regular re-assessment to monitor effectiveness of interventions, use of standardized protocols, management of conditions that may contribute to the development of wounds, management of conditions that may inhibit wound healing. Prevention of Pressure Injury Protocol documents a skin assessment will be completed upon admission and quarterly or with any significant changes including skin condition changes, pressure injury measurements will be completed weekly and the facility will "ensure appropriate Pressure Ulcer Prevention Protocols have been implemented including a dietary supplement to promote healing."</p> <p>1. R2's MDS (Minimum Data Set) dated 2/17/21 documents R2 is cognitively intact, totally dependent on staff for transfers and toileting, always incontinent of bowel and bladder, is at risk for pressure ulcers, and has one stage one pressure ulcer.</p> <p>On 4/5/21 at 12:30 pm, R2 was sitting up in a wheelchair in R2's room and stated R2 had</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>urinated in R2's incontinence pad twice already and is waiting to be changed. R2 stated that R2 won't get changed now "until after lunch" since staff will be serving lunch trays, even though R2 requested to be changed over 30 minutes ago. R2 stated V5 (Certified Nursing Assistant/CNA) just answered R2's call light and turned it off without providing any cares to R2. R2 stated R2 has open areas between R2's legs "because of lying in wet pads all day."</p> <p>On 4/6/21 at 9:20 am, R2 was lying in bed on a regular mattress and stated R2 was last changed around 5:00 am, before 3rd shift left and nobody has changed R2 since. R2 stated, "I take a triple dose of water pills and I've already peed twice. It is burning my sores. I shouldn't be sitting in this, but they are short staffed again today."</p> <p>On 4/6/21 at 10:10 am, V12 (CNA) entered R2's room to provide cares. R2's incontinence pad was saturated with urine and the soaker pad under R2 was also wet with urine. R2 had a cluster of two open, stage 2 pressure ulcers on R2's upper inner left thigh and a cluster of five stage 2 pressure ulcers to right upper inner thigh. R2 and V12 both stated R2 had these pressure sores for some time, and V12 stated, "They are not looking better, and might be worse." R2 and V12 both stated the nurses are aware of the multiple open areas and just want skin protectant on them.</p> <p>R2's Care Plan dated 3/2/2021 documents R2 is incontinent of bowel and bladder and is at risk for pressure injury due to incontinence and limited mobility.</p> <p>R2's Dietary Notes dated 2/18/21 by V15 (Registered Dietician/RD) documents R2's most</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>current weight is 277 pounds, and R2 is stable overall. R2 is on a regular diet and self-selects R2's own meals. R2's appetite is healthy and is free from swallow issues. R2 has no current labs to address and R2's "skin is free from pressure-related" injuries per the facility skin report.</p> <p>R2's Wound Evaluation and Management Summary Report dated 4/2/21 by V18 (Wound Physician) documents R2 has a "cluster" of "Shear (Pressure) Wounds" to the right groin measuring 4 cm (centimeters) by 0.5 cm by 0.1 cm that R2 has had for greater than 17 days that has had no change in condition. Treatment Plan is to apply a skin protectant cream with zinc to the wounds BID (twice daily). This Wound Evaluation does not document any pressure ulcers to R2's left inner thigh/groin.</p> <p>R2's medical record does not document any current pressure ulcers on R2's left inner thigh/groin until 4/7/21. R2's Progress Note dated 4/7/21 documents V19 (Wound Nurse) checked R2's left groin for open areas and two new areas noted: one measuring 2 cm by 1 cm and the other measuring 0.5 cm by 0.3 cm.</p> <p>R2's Physician Order Sheets do not document an order for any pressure ulcer treatment to R2's bilateral inner thighs/groin.</p> <p>On 4/7/21 at 10:15 am, V14 (Dietary Manager) stated V15 (RD) is at the facility three times a week. V14 stated V15 reviews all residents at least quarterly and with any changes. V14 stated skin issues are to be reported to V15 by the V19 (Wound Nurse) so nutritional recommendations can be made as needed.</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>On 4/7/21 at 10:19 am, V19 (Wound Nurse) stated when wounds develop, they are to be measured immediately and then a treatment obtained from the physician. V19 stated R2 has skin protectant cream in R2's room at bedside, because the "CNA's (Certified Nursing Assistants) can apply it." V19 stated physician orders are transcribed by V19 or V3 (Licensed Practical Nurse/LPN). V19 stated V19 isn't sure why V18's ordered pressure ulcer treatment was not transcribed, "but I (V19) know it is being done" because V19 has handed out the skin protectant with zinc. V19 stated V15 (RD) should get a tracking sheet with all skin issues weekly but that V19 is "behind on the wound tracking sheets due to being pulled to the floor so much, it's just hard to get everything done." V19 stated, "Staff need to make sure (R2) is clean and dry at all times." V19 stated V19 is "certified in skin care and urine can cause skin breakdown and skin irritation. It's unacceptable for staff to answer her call light and turn it off without providing cares; she needs changed when they come in, even if it means something else might need to wait a few extra minutes."</p> <p>On 4/7/21 at 10:43 am, V16 (Nurse Practitioner/NP) stated, "If a resident is incontinent of urine, they should be changed right away and not sit in a wet {incontinence pad} for 1-2 hours or more, like is happening. Of course, sitting in urine for hours and treatments not being done is the cause of these {R2's pressure} wounds developing and not healing." V16 stated R2 should be on a protein supplement also. V16 stated, "That is partly my fault for not ordering it but residents with skin issues are normally seen by the RD who makes those recommendations," then V16 approves them.</p>	S9999		
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S9999	<p>Continued From page 6</p> <p>On 4/7/21 at 12:03 pm, V15 (RD) stated V15 has not received a skin report since 3/4/21, so if R2's pressure ulcers weren't on that, V15 wouldn't know about them. V15 stated the 3/4/21 skin report only documented non-pressure alterations to the upper and lower back. V15 stated V15 "would like to get reports weekly or twice a month at minimum, that way I don't miss anyone." V15 stated if V15 had been made aware of R2's pressure ulcers, V15 would have recommended a sugar free liquid protein supplement, once or twice a day to "boost wound healing."</p> <p>2. R1's MDS dated 2/18/21 documents R1 is totally dependent on staff for bed mobility, transfers, and toileting. This also documents R1 is always incontinent of bowel and bladder and is at risk for pressure ulcers.</p> <p>On 4/5/21 at 12:40 pm, R1 was observed sitting up in bed on a regular mattress. R1 stated R1's buttocks hurt. R1 stated, "I don't know what is going on back there. They don't do anything with it. I get changed maybe three times a day. I haven't been changed since this morning when I got up." R1 also stated R1 doesn't remember the last time R1 got up and out of this bed, stating, "It's been that long ago, but I'd like to."</p> <p>On 4/5/21 at 1:08 pm, V7 (LPN) entered R1's room to make observations of R1's peri-area. R1's incontinence brief was saturated with urine. V7 did not change R1's brief or provide peri-care to R1.</p> <p>On 4/5/21 at 1:40 pm, V19 (Wound Nurse) entered R1's to make observations of R1's peri-area. R1's incontinence brief remained saturated with urine. At this time, R1 told V19 that R1 had a "sore area" on R1's buttocks that "hurts</p>	S9999		
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S9999	<p>Continued From page 7</p> <p>terrible." V19 rolled R1 onto R1's side to reveal an open area noted to the left buttocks. V19 measured the open area and described it as a stage two pressure ulcer measuring 0.5 cm (centimeters) by 0.3 cm. V19 then secured R1's incontinence brief, and exited R1's room without providing incontinence care or changing the saturated brief.</p> <p>On 4/5/21 at 1:55 pm, V4 (CNA) and V21 (CNA), the CNA's assigned to R1's unit, both stated they came into work at 6:30 am and that they had not provided any cares to R1 since arriving on the unit.</p> <p>On 4/5/21 at 2:30 pm, V22 (CNA) stated V22 was only assigned to R1's unit until 11:30 am but that V22 did not provide any cares to R1, including changing R1's brief.</p> <p>On 4/6/21 at 9:40 am, V12 (CNA) stated there is only three CNA's on the unit currently and at V22 (CNA) leaves at 11:00, leaving only two CNA's. V12 stated residents, including R1, are wanting to get up and out of bed but "when we only have two or three {CNA's}, we aren't able to get them {residents} out of bed due to several of them being {mechanical} lifts, requiring two {staff for assistance}."</p> <p>On 4/7/21 at 11:01 am, V13 (NP) stated R1 is immobile and requires two staff to move and reposition R1, and with R1 being incontinent, "that is the cause of R1's pressure area developing."</p> <p>(B)</p>	S9999		
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S9999	<p>Continued From page 8 (Violation 2 of 2)</p> <p>300.1210b) 300.1230b)1) 300.1230e) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</p> <p>Section 300.1230 Direct Care Staffing</p> <p>b) For the purposes of this Section, the following definitions shall apply:</p> <p>1) "Direct care" the provision of nursing care or personal care as defined in Section 300.330, therapies, and care provided by staff listed in subsection (i). Direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the facility (e.g., housekeeping).</p> <p>e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met.</p>	S9999		
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S9999	<p>Continued From page 9</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to have sufficient staff to meet the needs of the residents for toileting and providing incontinence care and transfers for three of four residents (R1, R2, R4) reviewed for staffing. These failures resulted in R1 and R2 developing multiple stage two pressure ulcers.</p> <p>Findings include:</p> <p>The Facility Assessment dated 2019 documents unit three of the facility as a long term care unit that provides general care including transfers, toileting programs, incontinence prevention and care, toileting assistance, skin care, wound care, pressure ulcer prevention and management.</p> <p>1. R2's MDS (Minimum Data Set) dated 2/17/21 documents R2 is cognitively intact, totally dependent on staff for transfers and toileting, always incontinent of bowel and bladder, at risk for pressure ulcers, and has one stage one pressure ulcer.</p> <p>On 4/5/21 at 12:30 pm, R2 was sitting up in a wheelchair in R2's room and stated R2 had urinated in R2's incontinence pad twice already and is waiting to be changed. R2 stated that R2 won't get changed now "until after lunch" since staff will be serving lunch trays. R2 stated R2</p>	S9999		
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S9999	<p>Continued From page 10</p> <p>requested to be changed over 30 minutes ago, and V5 (Certified Nursing Assistant/CNA) just answered R2's call light and turned it off without providing any cares to R2. R2 stated R2 has open areas between R2's legs "because of lying in wet pads all day."</p> <p>On 4/5/21 at 12:55 pm, V4 (CNA) stated unit three, where R2 resides, should have 5-6 CNA's due to having 49 residents on the unit. V4 stated, "Today we started with four but quickly went down to two but then back up to three CNA's. These residents deserve better. Basic cares are not getting done."</p> <p>On 4/6/21 at 9:20 am, R2 was lying in bed with R2's call light activated and stated R2 was last changed around 5:00 am before 3rd shift left and nobody has changed R2 since. R2 stated R2 had already urinated in R2's brief twice this morning. R2 stated the urine was "burning R2's sores. I shouldn't be sitting in this, but they are short staffed again today."</p> <p>On 4/6/21 at 9:23 am, V10 (Agency Registered Nurse/RN) stated unit three only has two CNA's on the floor working.</p> <p>On 4/6/21 at 10:10 am, V12 (CNA) entered R2's room to provide cares. R2's incontinence pad was saturated with urine and the soaker pad under R2 was also wet with urine. R2 had a cluster of two open, stage 2 pressure ulcers on R2's upper inner left thigh and a cluster of five stage 2 pressure ulcers to right upper inner thigh. R2 and V12 both stated R2 had these pressure sores for some time, and V12 stated, "They are not looking better, and might be worse." R2 and V12 both stated the nurses are aware of the multiple open areas and just want skin protectant</p>	S9999		

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S9999	<p>Continued From page 11</p> <p>on them.</p> <p>On 4/7/21 at 8:50 am, R2 stated R2 was "wet again and that no staff have bothered to change" R2. R2 stated, "They never do until after breakfast." R2 stated the last time R2 was changed was at 5:00 am and has urinated twice now in R2's brief. R2 stated V19 (Wound Nurse) tried to talk R2 into having a catheter placed yesterday. R2 stated, "Why should I do that, all that is going to do is benefit them. If they would do their job and toilet me and/or change me when needed instead of letting me sit in urine for hours upon hours, I wouldn't need a catheter and my bottom wouldn't look like it does."</p> <p>On 4/7/21 at 9:15 am, V17 (CNA) stated V17 was assigned to R2 and has been at work since 6:30 am. V17 stated V17 has not provided any cares to R2 yet because R2 doesn't like to get up until right before lunch.</p> <p>On 4/7/21 at 10:19 am, V19 (Wound Nurse) stated V19 is certified in skin care and "urine can cause skin breakdown and skin irritation. It is unacceptable for staff to answer R2's call light and turn it off without providing cares. R2 needs changed when they come in, even if it means something else might need to wait a few extra minutes. Staff need to make sure (R2) is clean and dry at all times."</p> <p>On 4/7/21 at 10:43 am, V16 (Nurse Practitioner) stated, "If a resident is incontinent of urine, they should be changed right away, and not sit in a wet {incontinence pad} for 1-2 hours, or more, like is happening. Of course, sitting in urine for hours and treatments not being done is the cause of these {R2's pressure} wounds developing and not healing."</p>	S9999		
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Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/08/2021
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL ROAD URBANA, IL 61802
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S9999	<p>Continued From page 12</p> <p>2. R1's MDS dated 2/18/21 documents R1 is totally dependent on staff for bed mobility, transfers, and toileting. This also documents R1 is always incontinent of bowel and bladder and is at risk for pressure ulcers.</p> <p>On 4/5/21 at 12:40 pm, R1 was observed sitting up in bed. R1 stated R1's buttocks hurts. R1 stated, "I don't know what is going on back there. They don't do anything with it. I get changed maybe three times a day. I haven't been changed since this morning when I got up." R1 also stated R1 doesn't remember the last time R1 "got up and out of this bed, it's been that long ago, but I'd like to." R1 was not able to call for assistance as R1's call light was lying on the floor.</p> <p>On 4/5/21 at 1:08 pm, V7 (Licensed Practical Nurse/LPN) entered R1's room to make observations of R1's peri-area. R1's incontinence brief was saturated with urine. V7 did not change R1's brief or provide peri-care to R1 before exiting R1's room.</p> <p>On 4/5/21 at 1:40 pm, V19 (Wound Nurse) entered R1's to make observations of R1's peri-area. R1's incontinence brief remained saturated with urine. At this time, R1 told V19 that R1 had a "sore area" on R1's buttocks that "hurts terrible." V19 rolled R1 onto R1's side to reveal an open area to the left buttocks. V19 measured the open area and described it as a stage two pressure ulcer. V19 then secured R1's incontinence brief and exited R1's room without providing incontinence care or changing the saturated brief.</p> <p>On 4/5/21 at 1:55 pm, V4 (CNA) and V21 (CNA), the CNA's assigned to R1's unit, both stated they</p>	S9999		
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL ROAD URBANA, IL 61802
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S9999	<p>Continued From page 13</p> <p>came into work at 6:30 am and that they had not provided any cares to R1 since arriving on the unit.</p> <p>On 4/5/21 at 2:04 pm, V20 (Scheduler) stated unit three, R1's unit, should have four CNA's based off the unit census. V20 stated the CNA's normally have a 1:13 or 1:14 ratio.</p> <p>On 4/5/21 at 2:30 pm, V22 (CNA) stated V22 was only assigned to R1's unit until 11:30 am but that V22 did not provide any cares to R1, including changing R1's brief.</p> <p>On 4/6/21 at 9:28 am, V11 (CNA) stated there are only 2 CNA's working unit three today. but normally there is four due to having so many residents on the unit that require a mechanical lift for transfers and other hands on assistance. V11 stated, "Residents stay in bed because we don't have the staff to get them up. We {staff} do our best to try and keep the residents dry and fed; that is really about all that gets done. It is rough."</p> <p>On 4/6/21 at 9:30 am, R1 was lying in bed and stated R1 was wet. R1 also stated that nobody has come to change R1 since sometime during the night. R1 was not able to call for assistance as R1's call light was out of reach.</p> <p>On 4/6/21 at 9:40 am, V12 (CNA) stated there are only three CNA's on the unit currently and at V22 (CNA) leaves at 11:00, leaving only two CNA's. V12 stated residents, including R1, are wanting to get up and out of bed but "when we only have two or three {CNA's}, we aren't able to get them {residents} out of bed due to several of them being {mechanical} lifts, requiring two {staff for assistance}."</p>	S9999		
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S9999	<p>Continued From page 14</p> <p>3. R4's MDS dated 1/1/21 documents R4 is cognitively intact, requires limited assistance for ambulation, extensive assistance for transfers and toileting, and is always continent of bowel and bladder.</p> <p>On 4/6/21 at 9:20 am, R4 activated R4's call light. At 9:40 am, R4's call light was still activated and R4 stated R4 wants to get up, get dressed and go to the bathroom. R4 stated, "I understand they don't have much help but how long do I have to wait. My light has been on for 20 minutes. It was on earlier too and they came in and shut it off, telling me that it was going to be awhile, that they only had two of them {CNA's} on the floor, and never returned." R4 stated that is happening more and more, with answering the call light and not providing assistance due to being short staffed. R4 stated, "I wish I could just get up and go myself so that I don't pee my pants again; that was so embarrassing." R4 was needing to go to the bathroom. R4's call light was answered at 9:51 am, 31 minutes after being activated the second time.</p> <p>On 4/7/21 at 10:43 am, V16 (Nurse Practitioner) stated if a resident is alert and oriented, and able to make their needs known and request to be toileted, staff should toilet them, and not make them wait.</p> <p style="text-align: center;">(B)</p>	S9999		
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