STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S 000	Initial Comments Annual Licensure & Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 4) 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)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	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 1 plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 2 2) All treatments and procedures shall be administered as ordered by the physician. 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 Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to follow a Physician's Order and weigh a resident daily to monitor for fluid overload for one of one resident (R103) reviewed for Edema in the sample list of 39. This failure resulted in R103 being hospitalized for five days for Congestive Heart Failure exacerbation. Findings include: The facility's Laboratory Tests policy with a review date of 9/27/17 documents, "Appropriate laboratory monitoring of disease processes and medications requires consideration of many factors including concomitant disease(s) and medication(s), wishes of the resident and family and current standards of practice." R103's Physician's Order Sheet (POS) dated 4/1/23 through 4/30/23 documents diagnoses of Congestive Heart Failure and Left Lower Extremity Cellulitis. This POS documents an order to weigh once daily and notify Physician if a three pound weight gain in one day or five pounds in one week. R103's Minimum Data Set dated 2/9/23 documents diagnoses including Atrial	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 3 Fibrillation, Heart Failure and Hypertension. R103's Treatment Administration Sheet (TAR) dated 3/1/23 through 3/31/23 documents an order dated 2/3/23 to weigh once daily and notify Physician if a 3 pound gain in one day or a 5 pound gain in one week. There are no weights recorded on this TAR from 3/1/23 to 3/31/23. R103's TAR dated 4/1/23 through 4/30/23 documents the same order with a start date of 2/3/23 to weigh once daily and notify the Physician if there is a 3 pound weight gain in one day or a 5 pound gain in one week. This TAR has no weights documented from 4/1/23 to 4/23/23. The facility's Monthly Weight Grid for May 2022 through April 2023 documents R103's weight in March 2023 was 119 pounds and then R103's weight in April 2023 was 146.6 pounds. R103's Nurse's Notes dated 4/6/23 at 6:00 PM documents R103 had a doctor's appointment and documents R103 was admitted to the hospital following the appointment and the note is signed by V6 Licensed Practical Nurse. R103's Cardiology Office Visit note dated 4/6/23 documents R103 stated that R103's legs felt much more swollen than when R103 discharged from the hospital. V30 Cardiology Advanced Practice Registered Nurse documents that R103 has orders for the facility to notify the Physician if R103's weight increases 2-3 pounds in 25 hours or 5 pounds in one week. V30 documents there has been no encounters where the extended care facility has notified them of any weight gain. V30 documents R103's weight was 135 pounds on 2/2/23 and on this day (4/6/23) it was 142 pounds. V30 documents the physical exam for R103 demonstrates +(plus) 2-3 edema to lower	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 4 legs and a skin tear with oozing of serous fluid to the right anterior lower leg. V30 documents R103 appears fluid overloaded. Oxygen was 73% (percent) on arrival. R103 has worsening peripheral edema and dyspnea (shortness of breath) on exertion. Send R103 to the emergency department for diuresis and further evaluation. R103's hospital discharge orders dated 4/11/23 documents R103 was admitted since 4/6/23 and documents orders to weigh daily and monitor blood pressure, look for signs and symptoms of heart failure such as shortness of breath, swelling of feet and legs and swollen or tender abdomen. Call provider if symptoms develop or if you gain more than 3 pounds in a day or 5 pounds in a week. R103's Nurse's Notes dated 4/11/23 documents R103 arrived at the facility at 5:02 PM and R103's admitting diagnosis was Acute Exacerbation of Congestive Heart Failure. On 4/25/23 at 11:44 AM, V22 Restorative Certified Nursing Assistant stated that V22 completes the weekly and monthly weights but the daily weights are supposed to be completed by the floor Certified Nursing Assistants (CNA). On 4/26/23 at 2:21 PM, V1 Administrator in Training stated that V22 Restorative CNA is supposed to complete the daily weights and V2 Interim Director of Nursing stated that if there is an order for daily weights they should be getting completed. (A) Statement of Licensure Violations (2 of 4)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 5 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 6 nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to investigate falls to identify root cause and develop/implement post fall interventions for two (R21, R26) of three residents reviewed for falls in the sample list of 39. This failure resulted in R21 falling and sustaining a forehead laceration that required sutures. Findings include: 1.) On 04/23/23 at 8:26 AM R21 was asleep in bed. R21 had bruising to R21's right eye and R21's right forehead was covered with a gauze dressing. On 4/23/23 at 12:48 PM R21's right elbow was covered with a gauze dressing. R21 stated R21 had two recent falls. R21 stated R21 fell out of bed and hit R21's head while reaching for something on the floor. R21 was sent to the hospital following the fall. R21 fell a few days prior to the other fall while attempting to walk to the bathroom. R21 was unsure what steps the facility has taken to prevent falls. R21 stated R21 only uses R21's wheeled walker when ambulating outside of R21's room, and R21 did not have R21's wheeled walker when R21 fell.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 7	S9999		

The facility's April 2023 Fall Analysis Log does not document that R21 fell on 4/19/23 and 4/21/23.

R21's Minimum Data Set dated 1/24/23 documents R21 has moderate cognitive impairment and requires limited assistance of one staff person for transfers, bed mobility, and toileting. R21's April 2023 Physician's Orders documents to administer Eliquis (anticoagulant) 5 milligrams by mouth twice daily. R21's Care Plan revised on 2/27/23 documents R21 has cognitive impairment and does not understand R21's mobility limits. Interventions include to observe and assess for use of mechanical devices and an interdisciplinary team review of assessments to determine safety interventions. This care plan does not identify R21 fell on 4/19/23 and 4/21/23 and does not document any post fall interventions after 2/27/23.

R21's Nursing Note dated 4/19/23 at 1:00 AM documents the following: At 10:15 PM, R21 was found on the floor of R21's room. R21 reported that R21 was walking without R21's walker towards the bathroom, opened the bathroom door, and fell. R21 did not have any injuries. R21's 4/19/23 fall investigation is incomplete, and does not document the root cause or that post fall interventions were developed/implemented.

R21's Nursing Notes document the following: On 4/21/23 at 9:00 PM documents R21 was found on the floor between the beds of R21's room. R21 was lying on R21's right side, head down, and partially on R21's abdomen. There was blood on the floor around R21. R21 had attempted to reach for an item on the floor, lost balance, and fell hitting R21's right elbow and right eyebrow causing laceration and hematoma

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 8	S9999		

(bruising/swelling.) R21 was transferred to the local hospital for treatment. R21 returned to the facility at 11:50 PM and the hospital closed R21's forehead laceration with glue.

R21's 4/21/23 fall investigation documents the following: Prior fall interventions include use of call light to request assistance and R21's call light was within reach. R21's walker was not in use at the time of R21's fall. The root cause is identified as R21 reached for an item on the floor, and R21 occasionally does not recognize R21's limitations. The new post fall interventions documented include R21 was educated on safety and to use the call light to request assistance.

R21's Emergency Room Note dated 4/21/23 documents fall, frontal head injury/laceration, contusion of right shoulder, and contusion with skin tear to right elbow as R21's reason for hospital visit. R21 was alert and oriented to person, place, time, and situation. R21 reported that R21 was sitting on the edge of R21's bed, reached for something on the floor, and fell forward striking R21's head. R21 had a 1-1.5 inch bleeding cut to the right upper eyebrow and two abrasions to the right elbow. The forehead laceration was closed with dissolving sutures.

On 4/25/23 at 9:55 AM V2 Interim Director of Nursing stated R21 fell out of bed and hit R21's head on 4/21/23, and the fall was unwitnessed. R21's head laceration was glued/closed at the hospital. V2 stated fall investigations are reviewed in the interdisciplinary team meetings. Root cause and post fall interventions are documented in the fall investigation and on the care plan. At 11:20 PM V2 stated the root cause of R21's 4/21/23 fall was that R21 attempted to reach for R21's snacks. The intervention implemented was to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 9 keep R21's personal items within reach. V2 was not aware that R21 had a prior fall on 4/19/23. V2 confirmed R21's 4/19/23 fall investigation was incomplete and did not include an identified root cause or that post fall interventions were developed/implemented. On 4/25/23 at 12:18 PM V17 Nurse Practitioner stated the facility should evaluate falls and implement interventions to prevent additional falls. V17 stated it is hard to say if R21's 4/21/23 fall would have been prevented if post fall interventions were developed and implemented, since R21 is alert and oriented. V17 confirmed educational reminders for use of call light and wheeled walker would be appropriate fall interventions for R21. 2.) R26's Minimum Data Set (MDS) dated 1/9/23 documents R26 as cognitively intact. This same MDS documents R26 as requiring limited assistance of one person for bed mobility and transfers. This same MDS documents medical diagnoses of Cerebral Vascular Accident (CVA) Left side affected, Congested Heart Failure and Left side Hemiplegia. R26's Care Plan does not include updated fall interventions after R26's 4/21/23 fall. R26's Nurse Progress Notes does not document a fall in April. R26's last nurse progress note was dated 3/23/23. R26's medical record does not document R26's 4/21/23 fall nor fall investigation. R26's Fall Risk Assessment dated 1/10/23 documents R26 as a high fall risk.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 10 Facility Fall Analysis Log dated January-April 2023 does not document any falls for R26. On 04/23/23 at 8:30 AM R26 stated "I fell the other day. I was sitting up on the side of the bed. I tried to raise up a bit to reach my phone. The bed shifted over so when I sat back down, I fell on the floor. The staff came and lifted me back up to sitting on the side of the bed again. They (staff) told me the bed was not locked. I did not get hurt thank goodness but that could have been bad. I can't use my Left arm or Left leg that well so I could have been really hurt." On 04/24/23 at 12:18 PM V2 Interim Director of Nurses (DON) stated she is unaware of R26 falling in recent history. "(R26) is alert and oriented. If (R26) said he fell, then he did. We (facility) were just not aware of it. No one reported it. All falls should be investigated. The resident care plan should be updated with each fall with the new interventions added. I will have to educate (V3) Care Plan Coordinator to include the dates on all new items added to the careplan. I know the careplans do not include dates with the fall interventions but we (facility) are working on that." On 04/24/23 at 12:24 PM V1 Administrator stated "(R26) is alert and oriented. This fall on 4/21/23 was never reported to me, it was never investigated and not included on the fall tracking because we (facility) did not know about it." On 4/25/23 at 1:30 PM V1 Administrator stated "I spoke with (R26) about his fall on 4/21/23. (R26) told me the staff put his cellular phone on the bedside table but it was on the far side away from him so he could not reach it. (R26) said he was trying to reach for his phone when the bed rolled	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 11 because it was unlocked so he fell. If the staff would have put (R26's) belongings within his reach, he never would have fallen. Another part of that problem was that the staff never reported this fall to me or (V2) Interim DON. The facility was not able to follow up, investigate the fall or update the care plan. We (facility) have to do better." The facility policy titled 'Fall Prevention' revised 11/10/2018 documents conduct fall assessments on the day of admission, quarterly and with a change in condition. If residents with a high risk code are observed up or getting up, help must be summoned or assistance must be provided to the resident. Immediately after any resident falls the unit nurse will assess the resident and provide any care or treatment needed for the resident. A fall huddle will be conducted with staff on duty to help identify circumstances of the event and appropriate interventions. The unit nurse will place documentation of the circumstances of a fall in the nurses notes or on an AIM for Wellness form along with the new intervention on the CNA assignment worksheet. Reports all falls during the morning Quality Assurance meetings Monday through Friday. All falls will be discussed in the Morning Quality Assurance meeting and any new interventions will be written on the care plan. (B) Statement of Licensure Violations (3 of 4) 300.610a) 300.1210b) 300.1210c)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 12 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to monitor and record urinary catheter output for three (R39, R5, R8) residents. The facility also failed to document	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

catheter care, ensure proper positioning of a urinary drainage bag, and timely treat a urinary tract infection for three (R39, R8, R10) residents. This failure affects four (R5, R8, R10, R39) of five residents reviewed for urinary tract infections and catheters in the sample list of 39. This failure resulted in R5 being hospitalized and diagnosed with a catheter malfunction and urinary tract infection.

Findings include:

A.1.) R5's Minimum Data Set (MDS) dated 1/26/23 documents R5 has severe cognitive impairment and requires extensive assistance of one person for toileting. R5's Care Plan dated 1/3/23 documents R5 has altered bladder elimination, neurogenic bladder, and a urinary catheter. Interventions include assess and report symptoms of urinary tract infections (fever, pressure, odorous urine, dark urine, pain, confusion, and abdominal distension), keep tubing free of kinks, intake and output every shift, and monitor/record changes in urine including urinary output.

R5's Nursing Notes document the following: On 1/16/23 at 6:48 PM R5 complained of burning and penile pain. Orders were received to change and flush R5's urinary catheter and obtain a urine sample for culture and sensitivity. R5's catheter was changed and R5 did not have any urinary output. R5 complained of some discomfort during catheterization. There are no documented nursing notes again until 1/17/23 at 2:00 PM when R5 was transferred to the emergency room for vomiting and complaints of lower abdominal pain.

R5's medical record does not document R5's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 14	S9999		

urine output was recorded daily or each shift in January 2023. There is no documentation that the facility collected a urine sample before R5 was transferred to the emergency room on 1/17/23.

R5's Hospital Summary of Care dated 1/17/23 documents R5 presented to the emergency room for vomiting. R5's urinary catheter balloon was found to be inflated within the urethra, and could be the cause of R5's abdominal pain. R5's urinary catheter was repositioned/replaced and a urine specimen was collected. R5 was given intravenous fluids and intravenous antibiotics, and was discharged back to the facility. R5's Encounter Diagnoses are listed as Recurrent Urinary Tract Infection, Malfunction of urinary catheter, and Systemic Inflammatory Response Syndrome.

R5's computed Tomography of the abdomen dated 1/17/23 at 5:18 PM documents R5's "(Urinary) catheter is malpositioned with the balloon inflated within the urethra. Small amount of air within the urinary bladder which is likely related to the (urinary) catheter." R5's Urine Culture dated 1/18/23 documents the urine contained greater than 100,000 colony forming units/milliliter of Staphylococcus aureus (bacteria).

On 4/24/23 at 8:59 AM V6 Licensed Practical Nurse (LPN) stated on 1/16/23 R5 had signs of urinary tract infection and V6 notified R5's physician. V6 changed R5's catheter and there was a minimal amount of urine returned. V6 stated there was not enough urine to collect a urine specimen. V6 stated R5 had some discomfort during catheterization, but R5 had been pulling on R5's catheter prior to catheterization. The next day R5 still had urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 15	S9999		

tract infection symptoms, complained of abdominal pain, and V6 transferred R5 to the hospital. V6 was not aware that R5's urinary catheter balloon was found to be within R5's urethra.

On 4/25/23 at 12:25 PM V2 Interim Director of Nursing (DON) stated urinary catheter output should be monitored and documented every shift on the output monitoring log. V2 stated if there is no urine output then the physician should be notified.

On 4/25/23 at 12:40 PM V17 Nurse Practitioner stated the nurses should be monitoring residents with urinary catheters for signs of drainage, blood, and odorous urine. Urine output should be monitored and recorded at least once per shift. If there is no urine output for 6-8 hours, then they should notify the physician. If notified of decreased urine output soul recommend a bladder scan, palpation of the bladder, adjusting the catheter placement, and assessing for pain prior to transferring the resident to the hospital. These are interventions/treatments that could be performed and possibly prevent hospitalization. Decreased urine output could be a sign of a blockage or catheter malfunction. Urine stasis could contribute to the development of urinary tract infections.

2.) On 4/23/23 at 8:26 AM R8 stated staff provide R8's urinary catheter care, but was unsure how often the catheter tubing is cleaned.

04/26/23 10:21 AM V8 Certified Nursing Assistant (CNA) and V27 CNA transferred R8 from the recliner into bed with a full mechanical lift. During the transfer, R8's urinary drainage bag was hooked onto the mechanical lift sling and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 16	S9999		

positioned above R8's bladder. Urine backflowed from the urinary drainage bag tubing towards the catheter tubing. R8's urine contained white sediment. V8 cleansed R8's catheter tubing in a downward motion and raised R8's urinary drainage bag in the air, above R8's bladder. R8's urine in the drainage bag tubing backflowed into R8's urinary catheter tubing/bladder.

R8's MDS dated 2/7/23 documents R8 is cognitively intact and requires extensive assistance of one staff person for toileting. R8's Care Plan revised 6/13/22 documents R8 has a suprapubic catheter (inserted through the abdomen) with interventions that include the use of tubing with anti-reflux valves, position the drainage bag below bladder level to prevent reflux, empty collection bag at least each shift and record urine output.

R8's April 2023 Physician's Orders document an order for urinary catheter care to be completed every shift. R8's April 2023 Treatment Administration Record (TAR) does not document catheter care was administered on 16 shifts between 4/1/23 and 4/23/23. There is no documentation that urine output is documented each shift.

On 4/26/23 at 10:35 AM V8 CNA stated the urinary drainage bag is suppose to be kept below the level of the resident's kidneys. V8 stated the CNAs are to do catheter care at least every shift and the urine output is reported to the nurse to document. V8 stated the CNAs do not document catheter care.

On 4/26/23 at 10:45 AM V12 LPN provided the urinary catheter drainage bags that are used for R8. The drainage bag does not contain an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 17 antireflux valve. At 10:50 AM V2 DON confirmed R8's urinary drainage bags do not contain an antireflux valve (to prevent urine backflow into the catheter) at the connection port that connects to the urinary catheter. 3.) On 4/23/23 at 8:50 AM R39's urinary catheter tubing contained yellow urine with white sediment. R39 stated the CNAs perform R39's catheter care. R39's April 2023 Physician's Orders includes orders to perform catheter care every shift. R39's April 2023 TAR does not document catheter care was administered 16 shifts between 4/1/23 and 4/23/23. There is no documentation that R39's urine output is documented each shift. On 4/25/23 at 12:20 PM V4 LPN stated catheter care is documented on the Medication/Treatment Administration Record. V4 confirmed there is no documented urine output recorded for R8 and R39 for April 2023. On 4/26/23 at 9:45 AM V2 Interim DON stated the nurses should initial the Treatment Administration Record and document refusals by circling the initials and recording the refusal in nursing note. The facility's Intake and Output policy revised December 2021 documents the CNAs obtain urine output every 8 hours and report the output to the nurse to document on the intake and output record. 4.) 04/26/23 08:59 AM R10's Physician Order Sheet (POS) dated April 1-30, 2023 documents medical diagnoses of Dysuria, Amnesia, Hypertension, Atrial Fibrillation, Chronic Kidney Disease Stage 3, Neuropathy and Macular	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 18 Degeneration. R10's Cognitive Assessment dated 3/16/23 documents R10 as cognitively intact. R10's Care Plan does not document updated interventions for R10's 4/19/23 medical diagnosis of Dysuria. R10's V23 Urology Progress Note dated 4/19/23 documents "Chief complaint: Dysuria. Dysuria started a couple of days ago. Facility states there was blood in (R10's) incontinence brief. (R10) has burning and frequency of urination for two days with no abdominal pain no back pain, nausea, vomiting, fever or chills. Orders placed this encounter: Nitrofurantoin Monohydrate/Macrocrystals (Macrobid) 100 milligrams (mg) capsules and Phenazopyridine (Pyridium) 100 mg tablet." R10's Nurse Progress Note dated 4/19/23 at 3:06 PM documents "(R10) out of facility earlier this shift with son, who transported (R10) to Urology appointments. (R10) had complained of frequency and discomfort. New order received from urologist. Macrobid and Pyridium therapy. Orders transcribed in Medication Administration Record (MAR) and communicated to oncoming nurse." R10's Medication Administration Record (MAR) dated April 1-30, 2023 documents a physician order dated 4/19/23 Macrobid 100 mg twice daily for seven days which was signed out as administered 4/20/23-4/26/23. This same MAR documents a physician order dated 4/19/23 100 mg three times per day for two days which was signed out as administered on 4/20/23-4/21/23. Facility Emergency Kit (Ekit) Contents Report documents Macrobid 50 mg capsules as being contained in EKit.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 19 On 04/23/23 at 1:36 PM R10 stated "I was prescribed an antibiotic at (V23's) Urology office for my Urinary Tract Infection (UTI). R10 stated "They (facility) let me wait an entire day before they (facility) gave me my antibiotic. (V23) Urologist told me I had a bad infection and needed treated immediately. I never had a problem with UTI's before I came in here (facility). But they (staff) make me wait to get changed so I just sit in pee. It is no wonder I got an infection." On 4/26/23 at 9:15 AM V12 Licensed Practical Nurse (LPN) stated "(V20) (R10's) family member took (R10) to a Urology appointment on 4/19/23. (R10) came back with orders for Macrobid 100 milligrams (mg) twice daily for seven days and Pyridium 100 mg twice daily for two days. I worked day shift that day and I remember there was some kind of delay for (R10's) Macrobid and Pyridium because (R10) is private pay so her family gets all of her medications. I never received (R10's) medications from the family before I left that day. The night shift nurse may have, but I did not. The facility has a box which emergency kit that has the Macrobid in it but since (R10) is private pay, we (staff) are not supposed to use medications from the emergency box for private pay residents." On 4/26/23 at 9:35 AM V20 (R10's) family member stated "(R10) made her own Urology appointment and then called me and asked me to take her. (R10) uses a wheechair so I came in to the facility and talked with them (staff). They (facility) took (R10) to the Urology appointment and I followed behind in my car. (V23) Urologist ordered two pills for (R10's) Urinary Tract Infection (UTI). One pill was an antibiotic and the other was for pain for (R10's) UTI. (V24) facility	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 20	S9999		

van driver drove (R10) back to the facility after her appointment. (V24) van driver had one of the bottles of pills with her to take back to the facility. After (V24) van driver got back to the facility, they (facility) called me and said that (V23's) office only filled one of the prescriptions and that they (facility) couldn't give one of the pills without the other. So I drove back to the clinic and had the other prescription filled. (V24) facility van driver met me back at the clinic so I didn't have to drive all the way across town again. I gave the pills to (V24) facility van driver. I did all that so that (R10) could get both of her medications started that same night of the appointment with (V23) Urologist."

On 4/26/23 at 9:40 AM V21 Registered Nurse stated V21 worked night shift the evening of 4/19/23. V21 RN stated "I have no knowledge of any pills being brought to the facility for (R10). Normally after hours the North hall nurse would answer the door and if there were any medications left for any of my residents, the north hall nurse would let me know and I would have to check them in. I don't remember if there were any medications brought to me but I don't think that they were."

On 4/26/23 at 9:45 AM V10 Registered Nurse (RN) stated "I remember that next morning when I came in I heard about (R10) being started on the Macrobid and Pyridium. There was some talk about the family having brought it in since (R10) is private pay so I checked the medication cart for her hall and the Macrobid and Pyridium were both in bottles sitting in the top drawer. The facility does keep the Macrobid in the emergency box butsince (R10) is private pay we (staff) would have the family bring the medication in since they (family) would have to pay for it. We (staff) are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 21	S9999		

not supposed to use the emergency box medications for private pay residents. I would if I had to but the family did bring in both medications the evening of 4/19/23. I am not sure why (V21) RN did not start those medications." V10 RN stated "There is not a Urinalysis or Culture for (R10) but I can look in the hospital systems records to try to find out about those."

On 4/26/23 at 10:45 AM V1 Administrator stated "(V24) facility van driver should not be transporting medications for residents. (R10's) Macrobid and Pyridium should have both been delivered to facility by a pharmacy."

On 4/26/23 at 2:00 PM V2 Interim Director of Nurses (DON) stated the facility did not follow up on R10's Dysuria that was treated with Macrobid (antibiotic). V2 stated there is no way to know if the antibiotic is working or not without having a Urinalysis or Culture and Sensitivity completed. V2 stated "the facility should have followed up with (V23's) Urology office but did not."

(B)

Statement of Licensure Violations (4 of 4)

300.610a)
300.1010h)
300.1210a)
300.1210b)
300.1210d)2)3)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 22	S9999		

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.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 23 provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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 Requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to provide adequate nutrition, identify significant weight loss, complete dietary assessments, intervene and follow up with	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 24 the physician and dietician for residents. These failures affect four (R5, R28, R45, R1) of four residents reviewed for weight loss and nutrition from a total sample list of 39. These failures resulted in significant weight losses for R5, R28 and R45. Findings include: 1.) R28's diagnosis include: falls, dementia, hypertension, gastroesophageal reflux, Osteoporosis, hiatal hernia, Barretts esophagus. On 4/22/23 at 12:45PM, after R28 had left the dining room, her plate was observed to have more than 90 percent of her food left on the plate. On 4/23/23 at 12:47PM, R28 was sitting at lunch with plate in front of her with no one attempting to assist her to eat. V28 Certified Nursing Assistant (CNA) gave R28 one bite of dessert and then said, "She doesn't eat well for us. Usually her husband comes to feed her," and then V28 CNA left the table. On 4/23/23 at 1:30PM, after residents had left the dining room, V5 Dietary Manager confirmed that R28 had only bite eaten from her plate. On 4/24/23 at 8:33AM, R28 was sitting at a dining room table with 3 other residents with a full plate of food. Staff are walking beside resident without assisting R28. R1, R28's table mate, began to feed R28. R28 continued to eat what R1 fed her. On 4/25/23 at 11:45AM, V13 Dietician said that she did not know anything about R28's weight loss until 4/24/23 when the facility dietary manager called her to inform her of R28's weight loss. V13 Dietician said that she had not	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 25 completed an assessment on R28, had never been a part of a weight meeting, and had not sent any recommendations for R28. V13 Dietician said that prior to the current dietary manager, the facility would not communicate with her about resident dietary needs. "Now, V5 dietary manager is communicating with me well, but she just started." The facility provided monthly weight grid document's R28's weights as the following in pounds: October 2022: 176.5, November: 178.6, December 2022: 178.2, January 2023: 170.0, February 2023: 167.10, March 2023: 160.10, and April 2023: 152.5. The above weight losses are calculated at a 10.29 percent weight loss from January 2023 to April 2023 and a 13.6 percent weight loss from October 2022 to April 2023. R28's undated care plan documents that R28 demonstrates dependency on a caregiver to assist with eating. On 4/25/23 at 12:00PM, V13 Dietician stated, "With (R28's) significant weight loss, we might have been able to prevent it. If she needs assistance with feeding, that needs to occur and I also need to be made aware of these residents so that I can intervene before the weight loss. With the system that they have had in place, I didn't know who needed to be seen and who didn't." 2.) R45's Physician Order Sheet (POS)dated 4/1/23 through 4/30/23 documents diagnoses including Physical Deconditioning, Diabetes Type 2, End Stage Renal Disease, Hiatal Hernia and Gastroesophageal Reflux. This POS documents	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 26 Diet Orders of No Added Salt, Carbohydrate Controlled Diet, Regular Consistency, Fortified Milk Shake Twice Daily and 1500 ml (milliliters)/day Fluid Restriction. The facility's Monthly Weight Grid May 2022 through April 2023 documents R45's weight for February 2023 as 154.2 pounds, March 2023 as 139.4 pounds and April as 127.6 pounds. This indicates a 9.6% weight loss in 30 days and a 17.25% weight loss in 60 days. R45's medical record documents a Dietary Services Communication form completed by V13 Dietician documents R45 has experienced a significant weight loss times three months and documents R45 was refusing meals and supplements. This form documents Dietary Recommendations that V13 discussed with R45 and R45 agreed to take a (liquid protein supplement) 90 ml (milliliter) twice a day and add a grape nutritious juice. This form is dated 3/19/23 and signed by V13. This form has a place for the Physician to approve and sign and that is blank. R45's Medication Administration Record dated 4/1/23 through 4/30/23 and R45's Treatment Administration Record dated 4/1/23 through 4/30/23 do not document an order for a liquid protein supplement or a grape nutritious juice. On 4/24/23 at 4:05 PM, V8 Dietary Manager stated that V8 has never seen the Dietary Services Communication dated 3/19/23 for R45 signed by V13. On 4/25/23 at 12:03 PM, V13 confirmed that V13 made these recommendation and that they should have been sent to the Physician to get an	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 27 order and then should have been implemented. V13 stated that V13 filled out the communication form and put in the Director of Nurse's box as requested by the Director of Nursing. R45's Dietary meal tray card documents R45 should have a Fortified Milk Shake at lunch and dinner. On 4/23/23 at 1:04 PM, R45 had R45's meal tray in R45's room. R45 had a pork chop, stuffing, sweet potatoes, roll, two bowls of chicken noodle soup, lemon pie, applesauce, saltine crackers, lemonade and water. There was no Fortified Milk Shake on R45's tray. On 4/24/23 R45 went to dialysis after breakfast. R45 did not receive a Fortified Milk Shake with the breakfast tray this day. R45 will not be in the facility for lunch so R45 will not receive a Fortified Milk Shake at lunch on this day. On 4/26/23 at 2:21 PM, V2 Interim Director of Nursing stated that staff should be following Dietician recommendations. 3.) The facility's Weight Report dated May 2022 - April 2023 documents R5's weights as follows: August 192 lbs. (pounds), September 195.2, October 184.2 (5.6% loss in 1 month), November 186, December is not recorded, January 171.4, February 161.6 (13.12% loss in 3 months/15.83% loss in 6 months), March 164.4, and April 164. R5's Minimum Data Set (MDS) dated 1/26/23 documents R5 has severe cognitive impairment, R5's current weight is 160 pounds, and R5 has not had a significant weight loss within the last month or last 6 months.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 28 R5's undated Care Plan problem area for Nutrition, documents the following: R5 is at risk for altered nutritional status and/or weight loss. R5 has had a decline with significant weight loss within the last 6 months and is on a No Added Salt Diet. The following undated interventions are listed as provide diet as ordered, refer to the Physician's Order Sheet (POS) for diet order, honor food preferences and dislikes, offer snack at bedtime and record amount consumed, monitor weights monthly or per the Registered Dietitian's (RD) recommendation, report significant weight changes to the physician and RD, follow the RD's recommendations, and assess current diet tolerance related to recent nausea/vomiting/diarrhea. R5's medical record does not document that R5's additional significant weight loss after October 2022 was reported to the physician and RD. There are no completed nutritional/dietary assessments after 6/23/22. R5's medical record does not document R5's weights between 10/12/22 and 12/31/22. R5's Physician Notification of Weight Change dated 10/12/22 documents R5 diet was regular and No Added Salt. The physician was notified of the one month weight loss of 5.64% loss and the interdisciplinary team recommended to continue to monitor R5's weights weekly for 4 weeks. R5's April 2023 Physician's Orders documents R5's diet as No Added Salt, thin liquids, and may have meal of the month on special occasions. There is no documentation that R5 has nutritional supplements/fortified foods as part of R5's diet. On 4/24/23 at 8:39 AM R5 was eating in the main dining room. R5's meal tray did not include any	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 29	S9999		

supplements/fortified foods. R5's dietary card does not document R5's diet includes supplements or fortified foods.

On 4/24/23 at 3:48 PM V2 Interim Director of Nursing (DON) stated when there is significant weight loss we notify the RD and physician and document the notification in the nursing notes. Nutritional interventions and the RD's recommendations are implemented. On 4/24/23 at 4:00 PM V2 stated the RD's recommendations are submitted to V2 by electronic mail and nursing follows up on getting approval from the physician to implement the recommendations. An order is then written and transcribed onto the POS and nutritional interventions are documented on the care plan. V2 reviewed R5's POS and Care Plan and confirmed there are no documented nutritional supplements or nutritional interventions to address R5's significant weight loss. On 4/25/23 at 12:25 PM V2 stated V2 was unable to locate any documentation of follow up, notification, and interventions to address R5's significant weight loss after October 2022. On 4/25/23 at 2:05 PM V2 stated V2 provided all of the weights that V2 could locate for R5 within the last year and confirmed there were no weights documented in R5's medical record between October 2022 and December 2022.

On 4/24/23 at 3:52 PM V5 Dietary Manager stated the RD comes to the facility twice per month. V5 stated nutritional assessments are completed quarterly and annually. R5 had a Urinary Tract Infection and was hospitalized around the time of R5's significant weight loss noted in October. The RD emails us the nutritional recommendations. The recommendations are placed in the resident's medical record. V5 gives the RD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 30 recommendations to the DON to review with the physician and implement the RD's recommended nutritional supplements. We did a weight review on R5 in January, and I thought we added a frozen nutritional supplement and nutritional juices. On 4/24/23 at 4:15 PM V3 Care Plan Coordinator stated significant weight loss is documented on the MDS and confirmed R5's January 2023 MDS does not identify R5's significant weight loss. On 4/25/23 at 11:53 AM V13 RD stated the facility has been inconsistent with reporting resident weight loss. The Dietary Manager is suppose to send V13 a list of residents to see at each visit and V13 expects to be notified of significant weight loss noted for 30, 90, and 180 days. V13 was not given a notification to evaluate R5 after November 2022. V13 stated V13 last evaluated R5 on 11/24/23 and completed a nutritional assessment at that time. V13 recommended a high calorie nutritional shake to be given three times daily with meals. V13's assessments are documented in the dietary section of the resident's medical record, and there have been issues with documentation being removed or missing from the records. Nutritional assessments are completed annually, quarterly, and with any significant weight changes. V13 is not always notified when the resident's annual assessment is due. V13 stated V13 would expect the health shakes to have been continued until R5 either refused them or R5's weight increased. V13 would recommend weekly weight monitoring if the resident is trending weight loss. V13 confirmed if R5's nutritional recommendations were implemented it could have prevented additional weight loss.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004212	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINI HERITAGE REHAB & HC	1315 CURT DRIVE, SUITE B CHAMPAIGN, IL 61821

(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) COMPLETE DATE
S9999	Continued From page 31 The facility's Resident Weight Monitoring policy dated as revised March 2019 documents weights are obtained monthly and reviewed by the Dietary Manager and DON by the 8th of the month. Monthly weights are recorded on the monthly weight report in the progress notes section of the resident's medical record. Significant weight loss of 5% or more in one month, 7.5% or more in 3 months, and 10% or more in 6 months are reported to the physician and dietitian. The resident's weights and nutritional status is reviewed by the dietary manager, interdisciplinary team, and dietitian, and interventions are recommended/implemented. The dietitian documents review, weight changes, and recommended nutritional interventions monthly in the dietary progress notes. Nursing is responsible to report the nutritional recommendations to the physician to obtain orders. (B)	S9999		