Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001457	A. BUILDING: _____ B. WING _____	C 09/23/2020

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

(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 Complaint Investigation #2067291/IL126803 #2067343/IL126862 #2067406/IL126922 #2067449/IL126968	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 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. 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: 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/22/20

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S9999	Continued From page 1 Section 300.3240 Abuse and Neglect a)An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not MET evidenced by: Based on record review, and interview, the facility failed to provide supervision and assistance with transfers and ambulation for one of three residents (R2) reviewed for falls on the sample list of 18. This failure resulted in R2 ambulating outside independently and being left outside unattended, where R2 fell and sustained a fractured hip. Findings Include: R2's Fall Risk Assessment dated 7/9/19 documents R2 is at high risk for falls. R2's Speech Language Pathology Evaluation dated 7/12/19 by V25 SLP (Speech Language Pathologist) documents R2 was referred to ST (Speech Therapy) by PT (Physical Therapy) due to frequent falls and a concern for safety awareness. Cognitive Communication Skills are impaired. R2 is oriented to person, purpose and caregivers but has impaired insight. R2 has 75% problem solving processes, 60% in new situations, 70% in judgement/inferencing, and 80% short term memory. R2 presents with mild to moderate cognitive linguistic impairment characterized by deficit in complex problem solving, recall, reasoning judgement, planning, and also with impulsive, unsafe and confused behavior.	S9999		

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S9999	Continued From page 2	S9999		

R2's MDS (Minimum Data Set) dated 7/16/19 documents R2 requires extensive assist of 2 staff for transfers and limited assist of one staff for ambulation.

R2's Care Plan dated 7/16/19 documents R2 was admitted to the facility with acute pain due to trauma with fractured ribs and is at risk for falls and injuries related to having a history of falls prior to admission and poor safety awareness.

R2's Discharge SLP Summary dated 7/29/19 documents R2 continues to benefit from staff supervision to decrease confusion, unsafe and impulsive behavior and cue for safety, especially relating to wheelchair.

R2's Progress Notes dated 7/28/19 by V41 LPN (Licensed Practical Nurse) documents, around 2:50 pm, it was reported that R2 was on the ground outside in the courtyard, with R2's left leg bent slightly underneath R2 and unable to move the leg. R2 had been observed pulling dead flowers out of a flower pot prior to the fall. An unidentified CNA (Certified Nursing Assistant) previously seated R2 on the bench with the flower pot next to R2. R2 had ambulated outside. R2 was taken a wheelchair and educated on walking unassisted.

R2's Fall Investigation includes a witness statement from V42 CNA dated 7/29/20 that documents, R2 walked outside to pick dead flowers out of a flower pot. We took R2, R2's wheelchair outside to R2. We locked R2's wheelchair in place and told R2 to use it if R2 got up. About ten minutes later, an {unidentified} family member came to V42 and told V42 that the family member seen R2 fall to the ground. V42

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S9999	Continued From page 3 went back out there {outside} and found R2 on the ground. R2's Final Investigation Report dated 8/2/19 documents, R2 was transferred to the Emergency Department and a closed comminuted intertrochanteric fracture of the left hip was confirmed by x-ray. R2 underwent surgical repair to the left hip on 7/29/19. On 9/15/20 at 10:15 am, V22 NP (Nurse Practitioner) stated, V22 did not work at the facility 1.5 years ago so V22 didn't know R2 however based off V22's medical experience, R2 should not have been left outside unattended with SLP, just two days prior, saying R2 needed supervision for safety recall. Had staff been outside with R2, they could have assisted with the transfer when R2 stood up, and prevented the fall. " A"	S9999		