IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.dph.illinois.gov

March 29, 2019

David Aronin, Registered Agent
Paradox Champaign Operator, LLC
2201 Main Street
Evanston, Illinois 60202

RE: Complaint #: IL00109071
Survey Date: February 04, 2019
Docket #: 19-C0121
Violation Type: Level A

Dear Registered Agent:

An investigation has been conducted by the Illinois Department of Public Health pursuant to a complaint concerning the long-term care facility known as Champaign Living Center.

Licensure

Pursuant to the provisions contained in the Nursing Home Care Act, or the ID/DD Community Care Act or the MC/DD Act, the Department must determine if each allegation in a complaint is valid, invalid or undetermined. The Department must also determine whether to cite a facility with one or more State violations or federal deficiencies (violations). The Department's determinations on the above referenced complaint are indicated on the attached "Complaint Determination Form." If your facility was cited with violations or deficiencies, then any rights you may have to a hearing will be described in the notices accompanying those violations or deficiencies.

If you have any questions, please contact the Division of Long-Term Care Quality Assurance at 217/782-5180 or, for the hearing impaired, the Department's TTY number at 1-800-547-0466.

Sincerely,

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations

Enclosure
cc: Administrator
File
Champaign Living Center/February 04, 2019//RegAgent/S.Geer

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS, Complainant,	)	Docket No. NH 19-C0121
v.	)	
PARADOX CHAMPAIGN OPERATOR, LLC, D/B/A, CHAMPAIGN LIVING CENTER, Respondent.	)	

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS; NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.) (hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Complaint IL00109071 Investigation conducted by the Department on February 04, 2019, at Champaign Living Center, 309 East Springfield Avenue, Champaign, Illinois 61820. On March 26, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Champaign Living Center, 309 East Springfield Avenue, Champaign, Illinois 61820 on December 28, 2018. The Facility's current license number is 0055467. The term of the conditional license shall be from April 26, 2019 to October 25, 2019. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON APRIL 26, 2019.

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license. However, the Imposed Plan of Correction must be followed.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of **$50,000.00**, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.1210b), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high-risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Fine = $25,000.00

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210d)3)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high-risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Fine = $25,000.00

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

(A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;

(B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or

(C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCQA.POCHearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.

Sherry Barr

Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulations
Illinois Department of Public Health

Dated this 29th day of March, 2019.

DISPLAY THIS PART IN A CONSPICUOUS PLACE

State of Illinois
Department of Public Health

LICENSE, PERMIT, CERTIFICATION, REGISTRATION

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

Ngozi Ezike, M.D.
Director

Issued under the authority of
The State of Illinois
Department of Public Health

EXPIRATION DATE	I.D. NUMBER
10/25/2019	0055467

LONG TERM CARE LICENSE CATEGORY BGBE
SKILLED 102

CONDITIONAL 102 TOTAL BEDS

BUSINESS ADDRESS
LICENSEE

PARADOX CHAMPAIGN OPERATOR, LLC

CHAMPAIGN LIVING CENTER
309 EAST SPRINGFIELD AVENUE
CHAMPAIGN IL 61820
EFFECTIVE DATE: 04/26/19

The face of this license has a colored background. Printed by Authority of the State of Illinois • 5/16

REGION 6 03/27/19

CHAMPAIGN LIVING CENTER
309 EAST SPRINGFIELD AVENUE
CHAMPAIGN IL 61820

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH STATE OF ILLINOIS Complainant, v. PARADOX CHAMPAIGN OPERATOR, LLC, D/B/A, CHAMPAIGN LIVING CENTER, Respondent.	)	Docket No. NH 19-C0121

PROOF OF SERVICE

The undersigned certifies that a true and correct copy of the attached Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; Notice of Placement on Quarterly List of Violators; and Notice of Opportunity for Hearing were sent by certified mail in a sealed envelope, postage prepaid to:

Registered Agent:	David Aronin
Licensee Info:	Paradox Champaign Operator, LLC
Address:	2201 Main Street Evanston, Illinois 60202

That said documents were deposited in the United States Post Office at Springfield, Illinois, on the 29th day of March, 2019.

Sammye Geer
Administrative Assistant
Long Term Care- Quality Assurance
Office of Health Care Regulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000301	A. BUILDING: _____ B. WING _____	C 02/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN LIVING CENTER	309 EAST SPRINGFIELD CHAMPAIGN, IL 61820

(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 # 1960659 / IL109071	S 000		
S9999	Final Observations Statement of Licensure Violations: (1 of 2) 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**	

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S9999	Continued From page 1	S9999		

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 toilet a resident upon request for one of three residents (R1) reviewed for falls in the sample of five. This failure resulted in R1 attempting to stand independently to clean R1's self after being incontinent, and subsequently falling. This fall resulted in a fractured lower leg requiring hospitalization.

Findings Include:

R1's Medication Review Report dated 1/30/19 documents Diagnoses of Muscle Weakness resulting in a need for assistance with personal care, and Repeated Falls.

R1's MDS (Minimum Data Set) dated 9/7/18 documents a BIMS (Brief Interview of Mental Status) of five (5) indicating R1 has severe cognitive impairments. This MDS also documents R1 requires extensive assistance of two staff for transfers, toileting, and is frequently incontinent of urine, and occasionally incontinent of stool.

R1's Incident Report dated 11/4/18 documents, V3 RN (Registered Nurse) heard R1 yelling "help" and upon V3 entering R1's room, V3 observed R1 half way lying on the floor with R1's head against the bed and R1's back against the wheelchair. V6, R1's spouse, was standing in

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S9999	Continued From page 2 front of R1. V5's, Medical Records/Former CNA (Certified Nursing Assistant) Witness Statement dated 11/4/18 documents, V5 attempted to help R1 into the bathroom but R1 was unable to stand up so V5 asked V4 CNA to assist. Once V4 and V5 were available to assist R1, R1 refused to stand up and transfer to the toilet. R1 instructed staff to take R1 out of the bathroom, so V4 and V5 returned R1 to R1's room, leaving R1 sitting in his wheelchair next to the bed, with V6 present. "Then about ten (10) minutes later, I (V5) was told by (V3) that (R1) was on the floor. Then I (V5) helped to get (R1) comfortable until the ambulance coming." V4's Witness Statement dated 11/4/18 documented the same information as V5's witness statement. R1's Investigation Report dated 11/4/18 by V1 Administrator documents, staff was called to resident room by his spouse. Noted R1 on the floor sitting with his back against the wheelchair, and legs out in front of him. Nursing Assessment notes internal rotation to the left ankle. 911 called and R1 was sent to the hospital. The Investigation Disposition documents, R1 were admitted to the facility on 8/31/18 for a right tibial fracture, repeated falls, and muscle weakness. R1 had been non-weight bearing since admission and R1 "just received weight bearing status on 11/1/18." V6 indicated R1 complained that he felt like he needed peri-care so V6 went to prepare a wash cloth for R1, and R1 was attempting to stand by himself {to clean self} when R1 fell to the floor. R1's ED (Emergency Department) Provider Notes dated 11/4/18 by V7 ER (Emergency Room) Physician documents, "Patient {R1} states that he	S9999		

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S9999	Continued From page 3 stood up today and rolled his ankle and felt a pop at which time he slowly lowered himself to the ground. There is obvious deformity to the left ankle and lower leg." X-ray of the left lower leg indicates comminuted distal tibia-fibula fracture extending into the intra-articular space. V8 Orthopedic Surgeon was consulted and will "reduce the fracture and place the patient {R1} in a splint in the ED and admit for further surgical repair. On 1/29/19 at 3:00 pm, V4 CNA stated, V4 doesn't really recall the situation but thinks V5 was assigned to him and that V4 might have assisted with toileting, due to location of assignments on the hall. V4 stated, R1 was a new stand pivot transfer with gait belt, and struggled was with the pivot, as R1 had been a mechanical lift transfer prior to that. On 1/29/19 at 3:18 pm, V5 Medical Records/Former CNA stated, we (V4 and V5) were trying to help R1 on the toilet. R1 was unsteady and getting frustrated and said "we will just wait". V5 asked if R1 was sure and R1 said yes. R1 "never made it to the toilet." We placed R1 back by his bed with his back towards the wall and we went into another resident room and said we'd be right back to see if he was ready to try and use the restroom again. While we were in the other resident room, V3 RN reported that R1 had fallen and V3 needed our help. "(R1's) pants were slightly down, to the middle of his buttocks" and R1 "had been incontinent of urine, (R1's) pants were wet." We asked R1 what happened and R1 told us V6 gave him something to clean himself up so R1 stood up and then fell.	S9999		
	On 1/30/19 at 2:30 pm, V3 RN stated, R1 use to be a mechanical lift but was told in report that R1			

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S9999	Continued From page 4 had been upgraded and was now able to bear weight. V3 stated V4 and V5 "never told me (V3) that (R1) was not able to stand and toilet. If they had told me, I (V3) would have told them to toilet (R1) how they use to, with a mechanical lift." V3 stated, all V3 knows is that V3 heard someone yelling help and V3 walked into R1's room and found R1 on the floor, "I (V3) could tell something was not right with his leg so I sent him to the hospital." On 1/31/19 at 9:35 am, V1 Administrator stated, "if someone is up in a wheelchair and unable to stand but needing to go to the bathroom, the staff should use a lift on them to place them on a commode, or back to bed for a bedpan. I was not aware that R1 was not toileted, that is not good." On 1/31/19 at 10:15 am, V2 DON (Director of Nursing) stated, V2 didn't know what therapy had recommended for R1 during the evaluation V2 would guess that R1 still should have been a mechanical lift since R1 had only just been evaluated, and therapy hadn't worked with R1 on bearing weight yet. "Even if they (therapy) did make him (R1) weight bearing, if (R1) wasn't able to stand, they {CNA's} should have used the lift" to toilet R1. (A) (2 of 2) 300.610a) 300.1210b) 300.1210d)3)6)	S9999		

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S9999	Continued From page 5 300.3240a) 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. 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: 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	S9999		

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S9999	Continued From page 6 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. 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 interview, and record review, the facility failed to initiate neurological assessments, and monitoring of a resident after multiple unwitnessed falls for one of three residents (R2) reviewed for falls in the sample of four. These failures resulted in a change of mental status condition for an undetermined time period, resulting in R2's hospitalization with an admission diagnosis of Subacute Subdural (brain) Hemorrhage. Findings include: The facility's Falls- Clinical Protocol policy dated August 2008 documents the staff will document risk factors for falling in the resident's record and discuss the resident's fall risk. This policy documents medical conditions affecting fall risk and the risk for significant complications of falls (for example, increased risk of bleeding in	S9999		

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S9999	Continued From page 7	S9999		

someone taking an anticoagulant) will be identified by the physician. This policy documents staff will evaluate, and document falls that occur while the resident is at the facility and staff will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture, or subdural hematoma have been ruled out or resolved. Delayed complications such as signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. This policy documents the staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.

The facility's Orders for Anticoagulants Policy dated February 2014 documents Should a resident receiving an anticoagulant have a fall or sustain a serious injury (i.e. head injury, laceration) the attending physician must be notified and the resident must be observed closely for bleeding or changes in mental status.

R2's Medication Review Report dated 1/29/19 documents R2's diagnoses including Repeated Falls, Peripheral Vascular Disease, Diabetes Mellitus with Diabetic Neuropathy, and Need for Assistance with Personal Care. This Report also documents medication orders including orders for Aspirin (Platelet Aggregation Inhibitor) 81mg (milligrams) by mouth three times a day every Monday, Wednesday, Friday and Plavix (Platelet Aggregation Inhibitor) 75mg by mouth one time daily.

R2's Incident Reports document unwitnessed falls dated as follows:

12/3/18 at 10:19pm- R2 had an unwitnessed fall,

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S9999	Continued From page 8 found at bedside. There is documentation of a neurological assessment at the time of occurrence, but no documentation of additional neurological follow-up assessments after 8:00am on 12/4/18. 12/4/18 at 12:06pm- R2 had an unwitnessed fall, found on the floor in front of R2's wheelchair. There is no documentation of neurological assessments post unwitnessed fall. 12/4/18 at 8:10pm- R2 had an unwitnessed fall, found lying on the floor on R2's back by R2's bed. There is no documentation of neurological assessments post fall. The facility's Investigation Report dated 12/6/19 (12/6/18) documents the following timeline: 8:09pm R2 was found lying on the floor on R2's back by R2's bed 9:55pm- Increase in agitation, sent to emergency room. This report documents a conclusion including: R2 has poor safety awareness, below the knee amputation, no shoes or socks, was up (arrow indicating up) "not able to redirect." There is no documentation in the conclusion related to the root cause of the fall or the concern related to the increase in agitation/condition status changes. R2's hospital Critical Care Team Consult / Intensive Care Unit History and Physical Note dated 12/5/18 documents R2 was admitted on 12/4/18 with diagnosis of Subacute Subdural Hemorrhage. This note documents R2 was transferred to the hospital after sustaining multiple falls at the skilled nursing facility, and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000301	A. BUILDING: _____ B. WING _____	C 02/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 9	S9999		

worsening altered mental status. This note documents R2's cognition worsened which prompted R2's transfer to the hospital. This note also documents the Principal Problem "SDH (Subdural Hematoma)" and Sub acute subdural hemorrhage probably secondary to recent fall.

R2's hospital Discharge Summary dated 12/8/18 documents R2's Discharge Diagnoses including Subacute Subdural Hematoma, likely secondary to fall, patient on Platelet Aggregation Inhibitors. This summary also documents R2 was instructed to not resume taking the Platelet Aggregation Inhibitors until addressed at a later unknown date.

On 1/31/19 at 12:20pm, V10, R2's Physician stated R2 has a very complex medical history. V10 stated R2 has a history of Peripheral Vascular Disease, Diabetes with Diabetic Neuropathy. V10 stated R2 is on Aspirin and Plavix medications which make R2 at a very high risk for bleeding. V10 stated R2 should have been sent to the hospital after any unwitnessed fall due to the high risk for bleeding injury post fall due to being on Aspirin, and Plavix medications.

On 1/31/19 at 2:35pm, V1, Administrator stated the facility has not been able to obtain the closed records for R2 from the previous owners of the facility as requested on 1/29/19. V1 stated from what V1 can see, the records have not been sent from where they are being stored as of 1/31/19 and there is no estimated date of when they will be sent as of 1/31/19. V1 stated the facility is unsure if there are neurological assessments located in the closed records for R2.

On 2/4/19 at 10:20 am, V1 Administrator confirmed there was no neurological assessment completed for either fall on 12/4/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 10	S9999		

(A)

LTC07202 COMPLAINT DETERMINATION FORM

FAC. NAME: CHAMPAIGN LIVING CENTER COMPLAINT #: 0109071
LIC. ID #: 0055467
DATE COMPLAINT RECEIVED: 01/29/19 09:36:00

IDPH Code	Allegation Summary	Determination
105	IMPROPER NURSING CARE	1

✓ The facility has committed violations as indicated in the attached*
___ No Violation

*Facilities participating in the Medicare and/or Medicaid programs will not receive a copy of the certification deficiencies as they have already received a copy through the certification program process.

Determination Codes

1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.

3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.