

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/05/2019
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTH ART BARTELL ROAD URBANA, IL 61802
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S 000	Initial Comments Complaint # 1963941/IL112661	S 000		
S9999	Final Observations Statement of Licensure Violation 300.1210b)5) 300.1210d)4)A)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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but	S9999	<h2>Attachment A</h2> <h3>Statement of Licensure Violations</h3>	

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

TITLE

(X6) DATE

06/28/19

Illinois Department of Public Health

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S9999	<p>Continued From page 1</p> <p>not be limited to, the following:</p> <p>A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident</p> <p>These Regulations were not met as evidence:</p> <p>Based on observation, interview and record review, the facility failed to toilet a resident upon request for one of three residents (R2) reviewed for toileting in the sample of eight. This failure resulted in R2 attempting to stand independently to clean R2's self after being incontinent of stool, subsequently falling and hitting R2's head on the sink. This fall resulted in a laceration to R2's head requiring staples.</p> <p>Findings Include:</p> <p>R2's MDS (Minimum Data Set) dated 3/21/19 documents R2 is alert and oriented, able to understand others and make R2's self understood. This MDS also documents R2 requires extensive assist of one staff for transfers</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>and toileting, is unable to balance self without staff assistance when moving from a sitting to standing position, or moving on and off the toilet, and is always continent of both bowel and bladder.</p> <p>R2's Face Sheet dated 6/5/19 documents the following Diagnoses: History of Falls, Hemiplegia and Hemiparesis following an Unspecified Cerebrovascular Disease affecting the right dominant side, Muscle Weakness, Difficulty Walking, and Contracture of the right hand.</p> <p>On 6/4/19 at 11:30 am, R2 was sitting in a wheelchair in R2's room R2 had a palm protector on R2's right hand. R2 stated R2 is not to get up by R2's self due to not having much use of R2's right side but "I {R2} do because staff don't come to help and when your pants are dirty, you don't want to just sit in it. They {staff} take a long time to answer the {call} light, and then tell you they will come back to assist and never do. I'm not like a dog, I'm potty trained. I just can't hold it and definitely don't like sitting in it." R2 stated R2 fell "about two months ago" because R2 had to use the restroom and an unidentified staff member answered R2's call light and "said they'd come back to take me to the bathroom and didn't. I pooped my pants." R2 stated R2 took R2's self into the restroom and turned on the {call} light, "I {R2} was trying to get onto the toilet and fell, hitting my head on the sink. I had to go to the hospital and get staples."</p> <p>R2's Event Report dated 3/30/19 at 2:28 pm by V7 LPN (Licensed Practical Nurse) documents, R2 had an unwitnessed fall while attempting to toilet self. Upon entering R2's room, V7 observed R2 lying on R2's back, underneath the sink. R2 was alert and calling out. Bathroom light was in</p>	S9999		
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S9999	<p>Continued From page 3</p> <p>use. R2 "was noted to have injury to back of head with light bleeding noted."</p> <p>R2's ED (Emergency Department) Provider Notes dated 3/30/19 by V10 ED Physician documents, R2 presented to the ED status post mechanical fall from standing height, and hit R2's "head on the sink going down." R2's right posterior scalp has a "+2 cm {centimeter} laceration."</p> <p>R2's Progress Notes dated 3/30/19 by V9 LPN documents R2 returned to the facility with a staple to the laceration on R2's head.</p> <p>The facility Resident Council Minutes document to following: 1/22/19 - "staff turn call lights off without helping residents or they do not return to help." 2/19/19 - "call light reported to be about 15-20 minutes with longer call light wait times in the evening/nights and at shift change", "staff are telling residents they are not their CNA (Certified Nursing Assistant) and turning off call lights without helping." 3/19/19 - "call light wait times reported as 15-20 minutes", "residents report that staff turn off call lights without always helping." 4/16/19 - "call light wait times reported as 30-45 minutes", "residents report that staff run off call lights without always helping."</p> <p>On 6/5/19 at 2:17 pm, V1 Administrator stated, V1 has only been employed at the facility a short time but has identified concerns and understands there is a problem with call lights, toileting, and falls.</p> <p style="text-align: center;">(B)</p>	S9999		
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