FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING IL6001630 02/03/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **500 SOUTH ART BARTELL ROAD** UNIVERSITY REHAB **URBANA, IL 61802** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPRO PRIATE TAG TAG **DEFICIENCY**) S 000 S 000 **Initial Comments** Complaint Investigation 2160585/IL130518 2160592/IL130525 2160616/IL130550 S9999 S9999 Final Observations Statement of Licensure Violation 300.610a) 300.1210b) 300.3300d) 300.3300e) 300.3300e)1)

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

Section 300.610 Resident Care Policies

Attachment A Statement of Licensure Violations

Illinois Department of Public Health

300.3300e)2) 300.3300e)3) 300.3300e)4) 300.3300e)5) 300.3300f) 300.3300g) 300.3300i) 300.33001)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C **B. WING** IL6001630 02/03/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 SOUTH ART BARTELL ROAD** UNIVERSITY REHAB **URBANA, IL. 61802 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE **DEFICIENCY**) S9999 Continued From page 1 S9999 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. Section 300.3300 Transfer or Discharge d) Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this Section and by a minimum written notice of 21 days. e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge. The notice required by subsection (d) of this Section shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act) 2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act) 3) A statement in not less than 12-point type. which reads:

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"You have a right to appeal the facility's decision

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
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	should not have to I a request for a hear Public Health within notice. If you requester than 10days at generally will not be during that time. If thearing is not in you be transferred or disexpiration of 30 day original notice of the form to appeal the frequest a hearing is questions, call the E	arge you. If you think you eave this facility, you may file ring with the Department of 10 days after receiving this est a hearing, it will be held not fiter your request, and you transferred or discharged he decision following the ur favor, you generally will not scharged prior to the scharged prior to the transfer or discharge. A acility's decision and to attached. If you have any Department of Public Health at per listed below."; (Section		80 18					
c 3	postage paid, pread Department; and (S 5) The name, addre the person charged	t form, together with a ldressed envelope to the ection 3-403(d) of the Act) ass, and telephone number of with the responsibility of sfer or discharge. (Section							
7.5	(e) of this Section as shall stay a transfer of the decision, unle have allowed transfed days as described us (2) of this Section of (Section 3-404 of the g) A copy of the notion of this Section as	ce required by subsection (d) and Section 3-402 of the Act e resident's clinical record			₩				

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	Findings include:		χ					
	R1's Progress Notes dated 1/27/21 documents							
	the following: 6:15 am - R1 appeared in good spirits. R1 is able to make R1's needs known. Call light within reach. R1 slept well through the night. Treatments done this morning. R1 voiced no							
				7.1 70.8				
	complaints of any kind this shift. 1:10 pm by V6 (Former Director of Nursing/DON)							
i	- Call placed to V30 (Nurse Practitioner/NP) to update on condition. "Discussion held that							
	concerns for sepsis and agreed to send (R1) to ER (Emergency Room) for evaluation of			W.				
	infection/sepsis." Ar	mbulance called and transfer						
	Sheet) sent with R1	and POS (Physician Order			**	:		
		documents the following vital emperature 97.6 and Oxygen						
	On 1/28/21 at 1:47;	om, V3 (R1's Family) stated nto the hospital on 1/27/21						
	thinking R1 had sep	sis. V3 stated V3 questioned						
	R1 was septic and v	s to the reasons V6 thought vas told that R1's vital signs						
	stated an unidentifie	R1 appeared confused. V3 ed Emergency Room Doctor				8.		
	stated there did not	appear to be anything wrong 't able to remain at the				2		
73	hospital, however R	1 is still there due to the		8				
	facility didn't give (R	ke R1 back. V3 stated "The 1's family) any discharge						
		We aren't in a place to be ome. (R1) needs oxygen and						
	a (mechanical lift)."	, , , , , , , , , , , , , , , , , , , ,				20		
		om, V4 (Ombudsman) stated nospital on 1/27/21 because it						

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stated V6 and V30 discussed that R1 had a

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