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 02/18/2021 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation 2160834/IL130789 2160945/IL130921 \$9999 Final Observations S9999 Statement of Licensure Violations 300.610a) 300.1210b) 300.3240a) 300.3300d) 300.3300e) 300.3300e)1) 300.3300e)2) 300.3300e)3) 300.3300e)4) 300.3300e)5) 300.3300f) 300.3300a) 300.3300j) 300.33001) 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 Attachment A the facility and shall be reviewed at least annually by this committee, documented by written, signed Statement of Licensure Violations

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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: __ B. WING_ IL6001630 02/18/2021 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 PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG 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 300.3240 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) 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)

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2) The effective date of the proposed transfer or

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6001630	B. WING		C 02/18/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
UNIVERSITY REHAB 500 SOUTH ART BARTELL ROAD URBANA, IL 61802						
(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 SHOUL) CROSS-REFERENCED TO THE APPROPROFILE OF CORRECTION CORRECTIO	D BE COMPLETE	
S9999	Continued From page 3		S9999	,		
	(Section 3-404 of the Act)					
	g) A copy of the noti (1) of this Section a shall be placed in the and a copy shall be Department, the rest representative, and, for in whole or part to Department of Healt (Section 3-405 of the j) The planned involutionally be discussed we resident's represent responsible for the resident's representation and disc involuntary transfer of facility administrator representative as the The content of the discussions and man clinical record. (Sectionally administrator in the resident is a have the opportunity with the Department receipt of the written transfer or discharge 3-410 of the Act) These requirements by:	ice required by subsection (d) and Section 3-402 of the Act the resident's clinical record transmitted to the sident, the resident's care is paid through Title XIX, to the thcare and Family Services. e Act) untary transfer or discharge with the resident, the ative and person or agency resident's placement, are in the facility. The cussion of the reasons for or discharge shall include the or other appropriate facility e administrator's designee. It is cussion and explanation in writing and shall include dividuals involved in the de a part of the resident's etion 3-408 of the Act) to involuntary transfer or colity, the resident's guardian aminor, his or her parent shall to file a request for a hearing a within 10 days following a notice of the involuntary the parent shall within the facility. (Section were not met as evidenced				
1	Based on record rev	iew and interview, the facility				

PRINTED: 04/05/2021 FORM APPROVED

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 02/18/2021 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 4 S9999 failed to permit a resident to return to the facility following a transfer to a hospital for evaluation. This failure affects one resident (R2) out of five reviewed for discharges on the sample of 13. As a result of this failure, R2 was required to return to the hospital to avoid being homeless. Findings include: R2's Electronic Medical Record Census Information documents R2 was admitted to the facility 1/10/20 and had no documented absences from the facility until the facility-initiated discharge on 2/4/21. On 2/10/21 at 10:34 am, V1 (Administrator) and V12 (Nurse Consultant) both stated, "Yes, (R2) is discharged, but that was not the intent when (R2) left here. We sent (R2) to the hospital to be evaluated on 2/4/21." R2's Minimum Data Set for Discharge dated 2/4/21 documents R2 was discharged from the facility to an acute care hospital as an unplanned discharge with return not anticipated. On 2/10/21 at 10:52 am, V13 (Admissions and Marketing Director/Hospital Liaison) stated. "I was present when the EMTs (Emergency Medical Technicians) returned (R2) to the facility from the hospital on 2/4/21. I went to the front door because I thought (R2) was not supposed to be coming back here." V13 further stated, "I got on the phone and talked to (V27, Emergency Room Doctor) who told me (V27) had evaluated (R2). gave (R2) a dose of Zyprexa (antipsychotic medication), (R2) wasn't aggressive, was cooperative, and there wasn't any reason for (R2) to be admitted to the hospital."

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