STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001630	A. BUILDING: _____ B. WING _____	C 05/06/2021

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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 2162961/IL133442	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1210b) 300.1210d)5) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent a facility acquired pressure wound from developing and worsening in one of three residents (R88) reviewed for pressure wounds in the sample list of 44. Findings include: Facility Policy Skin Assessments and Pressure Injury/Skin Breakdown revised date May 2021 documents, "2. In addition, the nurse shall complete weekly skin assessments as follows: a.	S9999		

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S9999	Continued From page 2 Weekly skin assessments will be completed by the nurse and documented in the electronic health record (EHR). b. If a wound is identified, the nurse will document in the EHR. Documentation may include full assessment of pressure injury/wound including: location, stage, length, width and depth, presence of exudates of necrotic tissue and wound bed; c. The nurse will notify the provider/primary SNF (Skilled Nursing Facility) team of new pressure injuries/wounds and obtain an order for a treatment." On 5/05/21 at 10:49AM, V17 (Licensed Practical Nurse/LPN) changed the dressing on R88's right leg wound and stated that V17 was not certain how the wound right leg wound occurred but that R88 did have a leg immobilizer when R88 returned from the hospital. The wound center was yellow with slough and baseball sized, however not measured. V17 stated, "It is large, and it needs to be debrided." R88's progress notes document on 3/5/21 R88 returned to the facility with a knee immobilizer. On 5/5/21 at 1:20 V33 (Certified Occupational Therapy Assistant/Director of Rehabilitation/COTA Director) stated that the immobilizer caused R88's right leg wound. V33 stated, "I told V24 (Licensed Practical Nurse/Wound Nurse) and the floor nurse about the wound as soon as we discovered it. It looked like a scab and it was about dime sized. A few weeks later the wound was worse, so I contacted the nurse practitioner to discuss quality of life and the wound and then it was discontinued." R88's Daily Physical Therapy Treatment note dated 4/7/21 documents, "Observed skin breakdown on right lateral posterior thigh.	S9999		

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S9999	Continued From page 3 Reported to nursing." R88's Occupational Therapy Daily Note dated 4/20/21 documents, "Nursing staff educated on new order to discontinue use of immobilizer brace." No wound care was documented in R88's medical record from 4/7/21-4/24/21. No skin checks, assessments, or other documentation identifying the wound were found in the medical record until 4/25/21, eighteen days after it was discovered and reported. R88's progress notes dated 4/25/21 documents initial care to right leg wound. R88's Initial Wound Doctor visit dated 4/30/21 documents right leg wound measuring 5.5 x 4.x .5 centimeters. R88's wound was surgically debrided and cleansed on this date. On 5/6/21 at 10:40AM V3 (Quality Registered Nurse) stated that R88's wound should have been addressed sooner and that the wound was preventable. On 5/6/21 at 9:44AM V44 (Nurse Practitioner/NP) stated that V44 would have expected the staff to treat a pressure wound once they knew about it. (B) (Violation 2 of 2) 300.610a) 300.1210b) 300.1210d)6)	S9999		

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S9999	Continued From page 4 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: 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	S9999		

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S9999	Continued From page 5 and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview and record review the facility failed to develop and implement fall interventions and failed to thoroughly investigate falls for three of seven residents (R108, R88, R57) reviewed for falls on the sample list of 44 residents. These failures resulted in R108 and R88 falling and suffering fractures when fall interventions were not put in place. Findings include: 1. The Minimum Date Set (MDS) dated 12/17/20 documents R108 is cognitively intact and requires extensive assistance with transfers. The Nurses Note dated 1/4/21 documents "resident's roommate yelled for help because resident (R108) was on the floor, resident stated that (R108) was going to the bathroom and fell, was assessed and picked up (off) the floor, no injury noted" The Fall investigation dated 1/4/21 documents R108 stated "I was getting up and my wheelchair was facing the wrong way so I tried to get up by myself, I can, but missed chair because it was facing the wrong way." R108's Care Plan documents a new intervention dated 1/5/21 to "place wheelchair facing resident next to bed." The Nurses Notes dated 1/6/21 documents "Resident (R108) is found by the CNA (Certified Nursing Assistant) by the side of the bed; (R108)	S9999		

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S9999	Continued From page 6 refused to be assessed and to take neurochecks; message left with MD (Medical Doctor) and POA (Power of Attorney) to call back to report the incident. Resident is transferred to the wheelchair and has no complaints of pain; is self transporting self in the unit." The Nurses Note dated 2/24/21 documents "(R108) yelled from (R108's) room for help. Nurse found (R108) on (R108's) bedroom floor near (R108's) bed with legs extended out toward (R108's) bed and head toward bathroom door face up with laceration of 2x2x0.1 cm (centimeter) on left elbow resident stated "I was going to get my food." Resident was removed from floor with (mechanical) lift. (R108) complained of pain in left elbow/arm." "Order received to send to ER for evaluation." The Hospital Summary of Care dated 2/25/21 documents R108 was readmitted to the facility on 2/25/21 with a laceration to R108's left elbow and a left humerus fracture. The Nurses Note dated 3/30/21 documents R108 underwent surgery to repair the left humerus fracture. The Fall Investigation dated 2/24/21 documents "(R108) is alert and oriented" and "Resident tried to transfer (R108's) self from the bed to the wheelchair and fell on (R108's) left side causing a laceration on the left elbow and a fracture on the left humerus." The 2/24/21 Fall Investigation does not document the location of R108's wheelchair prior to the fall. On 5/4/21 at 12:00 PM R108 stated no one asked R108 what happened when R108 fell (on 2/24/21).	S9999		

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S9999	Continued From page 7 On 05/05/21 at 08:29 AM V4 (CNA) stated (on 2/24/21) V4 fed R108 while R108 sat on the side of the bed and then V4 assisted R108 to lay back in the bed and left the room. V4 stated a few minutes later V4 was notified that R108 had fallen. V4 stated when V4 left the room after feeding R108 the wheelchair was not by R108's bed or within R108's reach. V4 stated the wheelchair was on the other side of the room. V4 stated R108 can only stand and pivot to the wheelchair and cannot walk. On 5/4/21 at 3:58 PM V3 (Quality Assurance Nurse) stated V3 did not interview V4 during the investigation into R108's 2/24/21 fall. V3 also stated V3 could not provide documentation of an interview with R108 to determine the cause of the fall. On 5/6/21 at 10:51 am V3 stated V3 could not find documentation of a fall investigation for R108's 1/6/21 fall. V3 reviewed the investigations for R108's 1/4/21 and 2/24/21 falls and stated "It looks like" R108 fell on 1/4/21 while trying to self transfer. V3 confirmed R108's care plan documents an intervention for staff to place the wheelchair facing the resident next to the bed. V3 confirmed that when R108 fell on 2/24/21 the wheelchair should have been next to R108's bed in case R108 tried to self transfer. V3 confirmed that if the wheelchair had been placed next to R108's bed it might have prevented R108's 2/24/21 fall. V3 stated R108 suffered a fractured humerus from the fall on 2/24/21. The Incident/Accident Investigation Policy and Procedure revised 10/2018 states "In order to ensure adequate and efficient monitoring of each incident which occurs the facility staff will	S9999		

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S9999	Continued From page 8 investigate the circumstances related to each incident occurrence." 2. R88's progress note dated 2/28/21 documents that R88 was observed on the floor of R88's room and that R88 complained of right knee pain. The progress note also states that an x-ray was ordered. R88's Final Investigation Report dated 3/4/21 documents the summary of investigation that the result of the x-ray from the on-call Nurse Practitioner showed a fracture of R88's right distal femur and R88 was sent to (local acute care) hospital. R88's Final Investigation Report dated 3/4/21 documents that R88 will be assessed for scheduled toileting upon return to the facility. No scheduled toileting program or frequent checks program was documented in R88's medical record. On 5/4/21 at 8;10AM V43 (Certified Nursing Assistant/CNA) stated when asked if a scheduled toileting program was documented for R88, "We don't do that." R88's progress note dated 4/7/21 documents R88 was observed on the floor of R88's room. R88's progress note also documents that R88 complained of pain to right hip and shoulder and that R88 was sent to (local acute care hospital) Emergency Room for evaluation and treatment. R88's Computed Tomography Exam read date 4/7/21 documents the test was taken after R88 sustained a fall resulting in mild compression deformities of L (Lumbar)1 and L4.	S9999		

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S9999	Continued From page 9	S9999		

R88's progress note dated 4/9/21 documents that R88 was returned to the facility with a diagnosis of a lumbar fracture.

No new fall interventions were documented on R88's care plan after the 4/7/21 fall.

R88's progress note dated 4/25/21 documents that R88 was observed on the floor next to R88's bed.

No new fall interventions were documented on R88's care plan after the 4/25/21 fall.

On 5/05/21 at 9:58 AM V37 (Licensed Practical Nurse/LPN) stated, "The only thing on her care plan is to toilet more frequently. I don't think we could provide 24 hour supervision and I don't see any other fall interventions."

The Facility's Falls Clinical Protocol revised date October 2017 documents 1. As part of the initial assessment, the facility will attempt to identify individuals with a history of falls and risk factors for subsequent falling. Treatment/Management 1. Based on the preceding assessment, the staff and physician may identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

On 5/6/21at 9:44AM V44 (Nurse Practitioner/NP) stated that V44 would have expected (fall) interventions to be put in place, especially after the first fall.

On 5/6/21 at 11:51am V3 (Quality Registered Nurse/RN) stated that V3 was responsible for investigating falls and no new fall interventions had been implemented. V3 stated, "They could

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S9999	Continued From page 10 have implemented a low bed and fall mats." V3 stated that the bed has the ability to go to a lower position and stated that they should have implemented other interventions to keep R88 from falling. 3. R57's Fall Risk care plan dated 12/17/20 documents R57 is at high risk for falling per fall risk assessment related to immobility and fall history. R57's Annual Minimum Data Set assessment dated 2/18/21 documents R57 as requiring total dependence for turning in bed with two person assist. R57's nurse's notes dated 2/15/2021 at 8:30 AM document R57 was found on the floor beside the bed in a fetal position facing towards the right side of the room. R57's nurse's notes dated 3/29/2021 at 12:15 AM documents R57 was found lying on the floor. V23's (CNA) witness statement dated 3/29/21 documents R57 was found face down on the floor. R57's Fall Risk Observation reports did not include a report for R57's fall on 2/15/21. R57's Fall Risk Observation report dated 3/28/21 documents R57 had an unwitnessed fall and was found on the floor. R57's report did not include an investigation of a root cause of the fall or an intervention to prevent further falls from bed. On 5/6/21 at 11:00 AM, V3 stated V3 is responsible for investigating resident falls. V3 stated R57 is immobile and V3 is unsure how R57 fell out of bed. V3 stated a root cause was not identified and V3 did not investigate and	S9999		

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S9999	Continued From page 11 determine the root cause of the falls on 2/15/21 and 3/29/21. V3 stated a new intervention was not put into place. The facility's Incident/Accident Investigation Policy and Procedure with a revision dated of 11/98 documents, "3. The result of the investigation will be utilized to determine the most appropriate intervention to be implemented to prevent similar incident. " (B)	S9999		