

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001630</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/24/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTH ART BARTELL ROAD URBANA, IL 61802</b>
---	---

(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  Facility Reported Incident of February 21, 2022 IL144999	S 000		
S9999	Final Observations  Statement of Licensure Violations:  300.610 a) 300.1210 b) 300.1210 d)6)  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	S9999	Attachment A Statement of Licensure Violations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001630</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/24/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTH ART BARTELL ROAD URBANA, IL 61802</b>
---	---

(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
S9999	<p>Continued From page 1</p> <p>nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</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>These requirements are not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to prevent a fall by failing to re-evaluate the need for a positioning aide for turning and positioning in bed and failing to provide safe turning and positioning while in bed, and failed to provide a safe transfer using a mechanical lift. These failures affected two of three residents (R1, R2) reviewed for accidents on the sample list of four. These failures resulted in R1 falling from the bed onto the floor sustaining a right hip fracture which required surgery to repair. These failures also resulted in R2 sustaining a left ankle and left knee fracture.</p> <p>Findings include:</p> <p>1) On 3/22/22 at 2:45 PM, R1 was sitting up in a wheelchair in the room. R1 stated, "I broke my hip after I rolled out of the bed. (V4, Certified Nurse's Assistant/CNA) was changing my (incontinence brief). I was too close to the side of the bed and was holding onto the wall and then rolled off the bed on the floor. I used to have bed rails that I would hold onto when they changed me, but they had me move to a new room and this bed doesn't have them. I am scared that I am going to fall out of the bed again." R1's bed did</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001630</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/24/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTH ART BARTELL ROAD</b> <b>URBANA, IL 61802</b>
---	---

(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
S9999	<p>Continued From page 2</p> <p>not have bed rails or any type of positioning device to assist with bed mobility. R1's bed was a foot from the wall.</p> <p>On 3/22/22 at 2:00 PM, V4, Certified Nurse's Assistant, stated, "I went into his (R1's) room to change him. I took his (incontinence brief) off and cleaned him up. He was turned to his side facing the wall and was supporting his body weight by putting his hand on the wall. I reached down to grab the (incontinence brief) which was at the foot of the bed and then I went to put the (incontinence brief) under him but he had removed his hand from the wall and his momentum caused him to roll forward and onto the floor. There was a gap between the wall and the bed. He was originally laying in the middle of the bed but when I rolled him he was closer to the edge."</p> <p>R1's nurse's notes, dated 2/21/2022, documents, "At 9:20 AM, R1) was being washed up and changed per (V4) as he was last changed at beginning of shift. As (R1) was lying on (left) side and (V4) was putting (incontinence brief) under buttock he rolled out of the bed onto floor."</p> <p>R1's nurse's notes, dated 2/22/2022 at 5:22 PM, documents, "Received order to send resident to (emergency room) for (evaluation) and (treatment) of right hip/leg pain (related to) fall on 2/21/22. Resident transported out of facility at 4:16 PM to (the hospital) by stretcher via (hospital) ambulance service. (R1) alert and oriented at this time, vitals (within normal limits), pain 10/10."</p> <p>R1's hospital discharge notes, dated 2/26/22, documents R1 was treated for a right hip fracture due to a fall. R1's right hip was surgically</p>	S9999		

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 03/24/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  UNIVERSITY REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 3</p> <p>repaired.</p> <p>On 3/23/22 at 12:00 PM, V5, Certified Nurse's Assistant, stated, "I used to take care of him (R1) when he was in the other room. His bed used to have bed rails which he would use to turn himself and hold himself over when we turned him in bed. His bed doesn't have the bed rails, and now we have to keep a hand on him to ensure he doesn't roll out of the bed. The use of the bed rails kept him in place and now I worry about him coming out of the bed."</p> <p>R1's medical record did not contain an evaluation for bedrails or a re-evaluation of bed mobility.</p> <p>On 3/23/22 at 1:00 PM, V2, Director of Nursing, stated V2 was unaware R1 utilized bed rails in R1's old room. V2 stated when residents move from one room to the other, typically the bed is moved with them. V2 stated V2 does not know why it wasn't. V2 confirmed R1 was not re-evaluated for bed mobility or the use of bed rails when R1 was moved to a different room.</p> <p>The facility's Fall's Clinical Protocol, with a revision date of October 2019, documents, "2. The staff and provider will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling." This protocol also documents, "3. If interventions have been successful in preventing falling, the staff will continue with current approaches or reconsider whether these measures are still needed if the problem that required the intervention (for example, dizziness or musculoskeletal pain) has resolved."</p> <p>2) On 3/22/22 at 2:40 PM, R2 was lying in bed. R2 was awake. R2 would whisper when</p>	S9999		

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 03/24/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  UNIVERSITY REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	<p>Continued From page 4</p> <p>speaking. R2 appeared disoriented. R3, who was sitting in a chair in the room, stated, "(R2) isn't the same since she got hurt. Her leg was broken because it got caught in the blankets when one of girls (Certified Nurse's Assistant) was lifting her with the machine (mechanical lift). It happened early in the morning when they got her up out of bed. She yelled out when she was lifting her. I haven't seen that girl since."</p> <p>R2's nurse's note, dated 3/09/2022 at 2:01 PM written by V6, Wound nurse, documents, "Writer was called to look at resident's left foot. Writer noted edema in the foot from the toes to the ankle, it is tender to touch also. There is a small light purple bruise on top of the left great toe measures 1 x 1 cm (centimeter)."</p> <p>R2's nurse's note, dated 3/09/2022 at 4:27 PM written by V6, Wound nurse, documents, "Writer was called to room to look at the left leg, resident has a bruised area that measures 20 x 18 cm from the anterior shin to above the knee. Area is tender to touch and resident complains of pain. She does not move her legs much per her normal. Called and advised (V3 Nurse Practitioner) and new orders were received to get an x ray of residents left knee and left tibia and fibula."</p> <p>On 3/23/22 at 1:19 PM, V6 stated, "I was called down to her (R2's) room on 3/9/22. The staff had found a bruise on her foot and wanted me to look at it because she was complaining of pain. She and (R3) said it got caught in the blankets when they were lifting her in the (mechanical lift) that morning. I called the Nurse Practitioner (V3) and she ordered an x-ray. When I got off the phone with her they called me down to the room again and her whole shin was bruised. It looked new</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6001630</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/24/2022</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 SOUTH ART BARTELL ROAD URBANA, IL 61802</b>
---	---

(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
S9999	<p>Continued From page 5</p> <p>and it was bright purple there was no fading. When I asked what happened, they both (R2 and R3) said again that it happened when her leg got tangled in the blankets that morning when they were lifting her. I called (V3) again and she ordered more x-rays. She never tried to get up by herself, she can't because her legs are stiff. She would get up once a day and watch TV. She could not do anything without staff assistance. She doesn't have siderails or anything that she could have bumped her leg on. The next day (V3) went down and looked at her and they (R2 and R3) told her the same thing."</p> <p>R2's nurse's notes, dated 3/11/2022 at 9:06 PM, documents, "(R2 complains of) left leg pain rating 10/10. Leg has a large discoloration of black and blue at the shin area, it's red and hot, painful when touch, (R2) unable to move leg, cried when this nurse try to reposition (R2), under the leg is hard in 3 areas and painful to touch also. PRN (as needed) Norco given, (physician) notified. Order to send (R2) out to (evaluation and treatment)."</p> <p>R2's hospital discharge summary, dated 3/12/22, documents, "Imaging consistent with left proximal and distal tibia fracture (left knee and ankle fracture). Patient (R2) is a (mechanical lift) at baseline. Nursing home notes indicate that patient's left leg was twisted during a transfer using the (mechanical lift)."</p> <p>On 3/23/22 at 1:29 PM, V3, Nurse Practitioner, stated, "When I came in on 3/10/22 and assessed her (R2), she said that when the staff transferred her the morning before that her leg was twisted in the blanket. Her fractures are consistent with that type of accident. The fracture had to have occurred then because there was no</p>	S9999		

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 03/24/2022
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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
S9999	Continued From page 6  other accident that happened. Also, (R3) is alert and oriented and stated when they transferred her, she yelled out in pain."  On 3/23/22 at 12:45 PM, V2, Director of Nursing, stated V2 investigated the incident. V2 stated it was reported by R2 and R3 that R2's leg got caught in blankets when unknown staff were using the mechanical lift. V2 stated R2 relies on staff assistance for all cares and could not have injured herself. V2 stated some contracted staff worked on the third shift that morning and could have gotten her out of bed. V2 stated V2 could not reach those workers, and they have not worked in the facility since. V2 stated her investigation did not reveal who got R2 up the morning the bruising was found. V2 stated R2 was confused at times prior to her fracture, but R2's account did not change. V2 stated R3 is alert and oriented, and R3's account of the occurrence remains the same as it did that day.  (A)	S9999		