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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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 Incident Report Investigation to Incident of 2/14/16 /IL 84247 Incident Report Investigation to Incident of 3/18/16 /IL 84257	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) 300.3240a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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 1 applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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: 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.	S9999		

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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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 2 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview and record review the facility failed to use a gait belt to transfer a resident (R1) requiring extensive assistance for transfers and failed to implement fall prevention interventions for two of three residents (R1 and R2) reviewed for falls in the sample of five. Failure to use a gait belt to transfer R1 resulted in R1 falling and sustaining a laceration with sutures. Findings include: 1. The Physician's Order Sheet dated 2/28/16 through 3/28/16 documents that R1 has diagnoses of Alzheimer's Disease and Multiple Sclerosis. The Minimum Data Set dated 12/9/15 documents that R1 requires extensive assistance with transfers. R1's Care Plan updated 3/2/16, documents an intervention of "transfers with gait belt and one person extensive assistance" dated 9/29/15. E6's (Certified Nurses Aide (CNA)) written statement dated 2/14/16 documents "I helped (R1) stand up (from the wheelchair) so that (R1) could get in bed and then (R1) said "I can't do it" and (R1's) legs got weak and started sliding under the bed. I yelled to E7 CNA.....I was trying to hold (R1) up to keep (R1) from falling.....we were able to put (R1) back in (R1's) chair but since (R1's) legs slid under the bed (R1) scrapped (R1's) right leg on the bed frame when	S9999		

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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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 3 we tried sliding (R1) out." E7's written statement dated 2/14/16 states "(R1's) legs were under the bed.....(E6) and I pulled (R1) out from under the bed and back into the chair. After we had (R1) in (R1's) w/c (wheel chair) we noticed that (R1) was bleeding....." The Nurse Note dated 2/14/16 states "(R1) laceration on right leg during transfer from wc (wheelchair) to bed. Size 4 centimeters (cm) x 3.5 cm x 1.5 cm.....send to hospital....." The Emergency Department Note dated 2/14/16 documents "(R1) presenting to (local) emergency department today c/o (complain of) Fall.....right leg pain.....large laceration there.....site repaired with ten..... sutures." The Initial/Final: (R1) Shin Laceration report dated 2/16/16 states ".....the contact with the bed frame caused the skin to tear." On 3/28/16 at 12:15 PM E6 stated that on 2/14/16 E6 was helping (R1) stand up from the wheelchair to transfer to the bed when R1's legs gave out and R1's legs slid under the bed. E6 stated E6 did not place a gait belt on R4 before trying to transfer R4 to the bed. E6 stated when R1 started sliding E6 held R1 up with E6's knee while holding R1's pants and arm. E6 stated E7 entered the room and assisted E6 to transfer R1 to the wheelchair. E6 stated E6 noted that R1's leg was bleeding after R1 was seated in the wheel chair. On 3/29/16 at 10:25 AM E13 Nursing Supervisor stated E13 assessed R1's right leg laceration on 2/14/16, and based on the direction of the skin flap, the laceration occurred when R1's leg slid	S9999		

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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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 4 under the bed and scrapped the bed frame. On 3/29/16 at 11:45 AM E2 Director of Nurses Stated that E6 should have used a gait belt to transfer R1 on 2/14/16 and using a gait belt could possibly have prevented R1's leg injury. On 3/30/16 at 10:30 AM Z9 Nurse Practitioner stated R1's leg laceration occurred when R1 fell on 2/14/16. On 3/29/16 at 4:20 PM R1's right shin was observed with E24 Registered Nurse. At that time a "U" shaped laceration secured with six skin closure strips was present on R1's right shin. E24 stated the wound has not healed yet. The undated Gait Belt policy states "gait belts will be used for resident transfer.....for any resident who.....is.....unsteady on their feet." 2. R2's Physician Order Sheet (POS) dated March 2016 documents R2's diagnoses include history of falling, Restlessness, Agitation, Transient Cerebral Ischemic Attack, Venous Insufficiency, Malaise, Osteoporosis and other abnormalities of gait and mobility. The POS documents and order dated 10/30/16 to admit R2 to hospice. R2's Minimum Data Set dated 11/7/15 documents R2 requires extensive assistance of two staff persons for bed mobility, transfers, and toileting and total dependence of one staff with wheel chair ambulation. R2's Fall Risk Assessment dated 11/7/15 documents R2 is at high risk for falls. R2's Physician Progress Notes dated 3/17/16 documents "...continued cognitive and physical decline..." The "All Falls for Facility" report dated 11/1/15 through 3/27/16 documents R2 had falls on 12/20/15 at 12:45 pm, 1/2/16 at 10:45 am,	S9999		

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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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 5 1/22/16 at 4:30 pm, and 3/18/16 at 1:49 am. The report does not document R2's fall on 12/15/15. R2's Nurses Notes dated 12/15/15 documents R2 was "found on the floor at bedside by CNA (Certified Nursing Assistant, E25). R2's Fall Occurrence Investigation Report dated 12/15/16 documents R2 "trying to self transfer... Sliding out of wheelchair...Was found on the floor unwitnessed..." The Employee Statement dated 12/15/15 documents "On 12/15/15 at 8:00 pm I (E25, CNA) heard an alarm going off in room (R2's)...found (R2) on the floor in front of her bedside table and her chair (wheel chair) across the room by the armoire (dresser)..." The report does not document a fall prevention intervention for R2's fall on 12/15/16. R2's Care Plan dated 11/13/15 does not document any fall prevention interventions related to R2's fall on 12/15/16. On 3/30/16 at 1:35 pm E2, Director of Nursing, stated R2's Fall Occurrence Investigation Report dated 12/15/15 does not document an intervention for R2's fall from the wheelchair. E2 also stated there were no interventions documented on R2's Care Plan for R2's fall on 12/15/15. R2's Fall Occurrence Investigation Report dated 12/20/15 documents R2's fall occurred on 12/20/15 at 12:45 pm. The report documents the root cause of R2's fall as "(R2) wanted to lay down and decided to help herself to get in her bed..." The Employee Statement from E23, Certified Nursing Assistant (CNA) dated 12/20/15 documents "I took (R2) to the bathroom and changed her then asked if she wanted to lay down and she said no. I went to lunch and came back and she was on the floor..." The report documents the intervention for "R2 to be put to	S9999		

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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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 bed after every meal." R2's Care Plan dated 11/13/15 documents "fall on 12/20/15 trying to put self to bed, had removed alarms and shoes. alarms d/c'd (discontinued), auto lock brakes put on wheel chair." R2's Care Plan also documents to "Put resident to be laid down bed after every meal for rest." R2's Nurses Notes dated 1/2/16 documents "... (R2) was on the floor in her bathroom ...sitting on the floor between her wheelchair and the toilet, brakes on the wheelchair, shoes on. (R2) stated wanted to use the bathroom and tried to transfer herself with asking you (for your) help..." R2's Fall Occurrence Investigation Report dated 1/2/16 documents R2's fall occurred on 1/2/16 at 10:45 am. E26, CNA, written stated dated 1/2/16 documents, "...after breakfast I toileted (R2) and I put (R2) back in her wheelchair..." The report documents the root cause of R2's fall as "(R2) wanted to use the bathroom and tried to transfer herself without asking/calling for help. The fall prevention intervention documents "(R2) to be toilet after every meal and to be layed (laid) down after every meal." On 3/30/16 at 11:00 am E2, Director of Nursing, stated E26, CNA, should have put R2 to bed after breakfast on 1/2/16. The "Assessing Falls and Their Causes" policy dated December 2007 documents "...When a resident falls, the following information should be recorded in the resident's medical record...Appropriate interventions taken to prevent future falls." (B)	S9999		

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 03/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	500 SOUTH ART BARTELL DRIVE 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