Illinois Department of Public Health

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 08/18/2022

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

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S 000	Initial Comments Complaint Investigations: 2266457/IL150149 2266548/IL150259 2266533/IL150234	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)3) 300.1220 b)2) 300.2900 d)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required.	S9999		

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to reassess and develop a plan of care for the risk of elopement (leaving the building unnoticed) and behaviors of wandering, when an increase in wandering and seeking exit doors was identified, failed to increase supervision when exiting behaviors occurred, and failed to ensure a door alarm was activated to notify staff if a resident leaves the building for one (R1) of 16 residents reviewed for elopement on the sample list of 16. These failures resulted in R1 exiting the facility unnoticed, at night, unsupervised, through an un-alarmed door, then ambulating down a dark road which was along side a wooded area. R1 had an unwitnessed fall near a parking lot and sustained a lip injury, facial bruising, pain, and an acute oblique fracture of the left wrist and nondisplaced left lateral seventh and eighth rib fractures. Findings include: The facility's Initial report to the State Agency documents, "On 8/13/22 at 9:00 PM, (R1's) call light was alarming. Staff entered room and was unable to locate resident. Staff initiated search for resident and noted exit door to Unit 2 had been opened. Staff was able to locate R1 outside the facility on the ground." This report also documents, "At 6:35 AM on 8/15/22, (V10, R1's Family Member) requested to send (R1) to the ER (emergency room). (R1) was sent to ER per ambulance upon receiving order from	S9999		

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practitioner. ER notes indicate acute oblique fracture of (left) wrist and nondisplaced left lateral seventh and eighth rib fractures."

On 8/16/22 at 10:19 AM, V1, Administrator, walked the route in which R1 took on 8/13/22, the night R1 eloped. V1 walked from R1's room down the hall and around the corner into an adjacent hallway, then walked to a door in the middle of the hallway leading to a courtyard. V1 pushed on the door, and the door alarmed and did not open. The light on the door handle was green. V1 stated, "If the light is green then the alarm is activated." V1 then used a key to turn off the alarm, and the light turned red. V1 then walked outside and walked through the courtyard, then turned left down a narrow road. There was a wooded area along the road and a small grassy pathway between the wooded area and road. V1 then walked down the road, and stopped near the facility's parking lot. V1 stated R1 was found laying in the grass between the road and the wooded area. V1 stated the distance R1 walked from the exit door was 383 feet, and that along the road and wooded area there are no lights.

On 8/16/22 at 9:30 AM, V4, Certified Nurse's Assistant (CNA), stated on 8/13/22 at about 7:00 PM, "(V12, CNA) came to the hallway and I told her I was going to take a break. The back door was alarming, and (R1) was down there trying to get out. We got her back in, and I went back in to the desk. (V13, Registered Nurse) had the keys to shut off the alarm, and the alarm wasn't turned back on. About an hour later, I was coming out of a resident room and (V12) asked if I had seen (R1). We looked room to room and we saw (V14, CNA) and asked if she had seen her, and she told us she had seen her trying to get out the back door where we clock in at. That was at 8:00

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PM. So (V12) went to go get her, and brought her back. The call lights were going off like crazy. So around 9:00 PM, I went in to take care of another resident. (R1) was close to (R1's) room. (V12) came in and told me she was going to pick up her food. When I walked out of the room, I heard call lights going off. (R1's) light was going off, and I went in there and she wasn't in there. Her walker and wheelchair were in the room. So I went and asked (V15, Licensed Practical Nurse (LPN)) if she had seen her, and she said no. So, I said 'ok', and went to the hall where she was at, and I checked everyone's room and bathrooms, and (V15) was also checking some rooms and bathrooms. We didn't find her, so she told me she was going to unit 1. Then I called unit 5, and spoke to (V16, CNA), and she told me she was going to check unit 4. When I was on the phone with (V16, CNA), I told her all the doors were locked. Then she told me if the door alarm was red and not green; that meant it was unlocked. So we went and looked out the door and didn't see her. So we came back in, and I saw (V16) running down the hallway, so me and (V16) went back outside with flashlights, and went looking around the patio, and we turned left and kept looking' then I saw something across the other side. She was on the other side of the little road down by the parking lot. She was by the woods on the other side of the road where cars can go through. It was pitch dark, and (R1) was laying on the ground. She was wrapped up in a blanket. She was lying on her side. Her mouth was bloody. We saw two other CNAs, and we screamed for help. It was (V14) and (V17). (V14) went in to get some help. When (R1) was inside, we assessed her. There didn't seem to be anything wrong, except her mouth was bloody. Her face wasn't bruised, but then later her face was swelling and getting bruised. Other CNAs

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told me she tried getting out before. She got a long ways from the door."

On 8/17/22 at 10:43 AM, V13, LPN, stated, "(R1) was exit seeking before she left. I was heading out to leave. (V12, CNA) was trying to shut the alarm off, but she couldn't figure out how to turn the alarm on or off. She had a bunch of keys, and I didn't know which key would turn off the alarm. So I gave her my key to go turn off the alarm. So she went and turned off, the alarm and gave me back the keys." V13 stated R1 was very confused and she was not sure where she was at. V13 stated R1 will think she is in a whole other town or in a business meeting. V13 stated R1 is always very disoriented.

R1's Nurse's note, dated 8/08/2022 at 10:00 PM, written by V18, LPN, documents, "(R1) was agitated at start of shift, getting up out of wheel chair, ambulating without assistance, going toward exit door and screaming."

On 8/17/22 at 10:52 AM, V18, LPN, stated on 8/8/22 at 10:00 PM, she was coming into work and noticed R1 up at a door that exited the facility. V18 stated she had gotten out of her wheelchair and was at the door. V18 stated she had been wandering a lot more and going up to the doors in the last couple of days prior to that day. V18 stated she was very confused and was attempting to get out of her chair and walk more. V18 stated she didn't tell anyone, but documented it.

On 8/16/22 at 11:02 AM, V6, Social Service Director, stated she does the elopement risk assessments. V6 stated she completed R1's elopement risk assessment on 8/5/22. V6 stated since she hadn't tried to find the door or exit, or

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making any statements, and there was no family report of those issues, so she determined she didn't need to be added as an elopement risk. V6 stated she would redo the assessment if there was an attempt after doing the assessment. "If they are at risk we add them to the elopement program. I should be notified of elopement attempts so we can start the process. We go through behaviors in the morning meeting, and the note from the 8th was discussed, and since she was wandering and didn't go through the door we didn't put her on the program. I did not talk to the nurse (V18) who made the note." V6 stated staff should be monitoring the resident more closely when they are making multiple attempts to get out and to ensure the doors are alarmed. V6 stated supervision should have been increased when R1 was attempting to leave.

R1's care plan contains a careplan for elopement, dated 8/14/22. This care plan does not document interventions or a care plan for wandering or potential elopement risk prior to 8/14/22, after R1 eloped on 8/13/22.

On 8/16/22 at 1:38 PM, V9, Nurse Practitioner, stated she saw R1 twice while she was in the facility. V9 stated she was admitted on 8/1/22 from the hospital, with a new diagnosis of epilepsy, and while in the hospital she was having delusions. V9 stated R1's cognition was declining pretty rapidly. V9 stated, She had very poor safety awareness, and she had obsessive thoughts. She would not be safe to walk around outside by herself. She needed to be placed on a memory care unit or in a memory care facility." V9 stated R1 would not be safe at all around a road, and she was very debilitated and was falling in the facility. V9 stated if she got out by herself and

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S9999	Continued From page 7 was not found, she could have developed rhabdomyolysis (breakdown of muscle tissue) and passed away. V9 stated, Pretty significant harm occurred and could reoccur to (R1) if left unsupervised; she can not take care of herself." The facility's Wandering, Unsafe Resident policy, with a revision dated of February 2019, documents, "The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. This policy documents, "2. The staff will assess at-risk individuals on admission, annually and significant change in condition for potentially correctable risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring and (departure alert) bracelets will be included." (A)	S9999		