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
	IL6001457	A. BUILDING: ____ B. WING ____	C 09/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN URBANA NRSG & REHAB	302 WEST BURWASH SAVOY, IL 61874

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S 000	Initial Comments Complaint Investigations: 2267614/ IL151507-F689 2267689/ IL151585-F695	S 000		
S9999	Final Observations Statement of Licensure Violation1 of 2: 300.610a) 300.1210a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 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 applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1 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. (Section 3-202.2a of the Act) 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	S9999		

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and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to implement increased supervision after a fall resulting in a second and third fall and subsequent injuries for one cognitively impaired resident (R1). This failure resulted in R1 being sent to the Emergency Room, diagnosed, and treated for multiple right side rib fractures, a Cervical-5 (C5) fracture, Lumbar-4 (L4) compression fracture, forehead laceration, and skin tears. R1 is one of three residents reviewed for falls in the sample of three.

Findings include:

R1's Minimum Data Set dated 9/16/22 documents

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R1 is severely cognitively impaired and requires limited assistance of one staff person for transfers.

R1's Fall Risk Evaluation dated 9/16/22 documents R1 is at high risk for falls related to intermittent confusion, 1-2 recent falls, ambulatory, balance problems while standing and walking, requires assistive device (walker), has medical diagnoses and takes medications that also put him at risk.

R1's Incident Report dated 9/21/22 documents at 1:50 AM, R1 was heard yelling that he was falling and was found on the floor by his bed. R1 stated he was getting dressed to go home. At the time of the fall, R1 was orientated to person and had impaired memory, confusion, gait imbalance, recent illness, and had poor safety awareness related to Dementia. R1 was assessed for injuries and helped back to his bed. Neurological checks were started. The last neurological check was documented at 3:35 AM.

R1's Incident Report dated 9/21/22 documents at 4:20 AM, R1 was yelling that he had fallen and was found in his room on the floor by his nightstand. R1 had a laceration to the right forehead and skin tears to his right arm and right knee. R1 was transported to the Emergency Room (ER).

R1's Computed Tomography (CT) results dated 9/21/22 document R1 fell from a standing position and sustained a large laceration to his forehead, multiple acute right lower rib fractures, acute-subacute appearing L4 compression fracture, and an acute non-displaced fracture of the left C5 posterior transverse process.

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R1's Nurses Note dated 9/21/22 documents R1 returned from the ER with 11 staples to his forehead laceration and a cervical collar in place.

R1's Incident Report dated 9/23/22 documents at 3:10 AM, R1 was walking in the hallway outside of his room with his walker and fell sideways to his right onto the floor. R1 reopened his forehead laceration from 9/21/22 and skin tears to his right arm. R1 was transported to the Emergency Room (ER).

R1's Hospital History and Physical Note dated 9/23/22 documents R1 presented in the ER after recurrent falls. R1 was seen in the ER two days ago after a fall in which he suffered a left C5 fracture, right rib fractures, and lumbar fracture of indeterminate age. R1 also had a forehead laceration which was re-opened with this current fall.

On 9/27/22 at 1:15 PM V16 Registered Nurse stated she was R1's assigned nurse during all three falls on 9/21/22 and 9/23/22. V16 stated R1 had been moved to first floor on 9/16/22 due to testing positive for Covid-19. He was on isolation in a room that was at the end of the hall furthest from the nurses' station. R1 was a high fall risk, had poor safety awareness, and was confused. On 9/21/22 at 1:50 AM, V16 found R1 on the floor in his room. V16 stated R1 didn't appear to have any injuries so they started neurological checks. R1 was last checked at 3:35 AM. He was in bed with no neurological changes noted. At 4:20 AM, V16 heard R1 call out and went down to his room. R1 had fallen again and hit his head on the bedside table. There was blood all over his head and the table. R1 was transported to the ER.

On 9/23/22 V16 was again R1's nurse and at

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S9999	Continued From page 5 about 3:10 AM V16 noticed R1 walking in the hall with his walker. V16 stated she yelled for someone to get him, but they couldn't get to him before he fell over and hit his head on the floor and reopened his forehead laceration and skin tears. V16 stated there wasn't any new fall interventions put in place between the first fall, second fall, and third fall that she was aware of. V16 stated she was monitoring R1 more frequently during his neurological checks after his first fall on 9/21 but when the time frame moved to every hour, that is when he fell. V16 confirmed that visual monitoring should have been more frequent in order to prevent further falls. On 9/28/22 at 10:00 AM V4 Minimum Date Set Registered Nurse confirmed R1 was a confused resident with dementia, high fall risk, balance issues, and low safety awareness. He had previous falls and with his newly diagnosed Covid infection, he was even a higher fall risk than normal. He was also at higher risk because he was on isolation and at the end of the hall furthest away from the nurses' station. V4 confirmed R1 should have had more fall interventions in place and should have been supervised more closely, especially after his first fall on 9/21/22. These things could've potentially prevented the falls and subsequent injuries. On 9/28/22 at 1:52 PM V3 Medical Doctor confirmed R1 was a confused resident with Dementia, high fall risk, balance issues, and low safety awareness. He had previous falls and with his newly diagnosed Covid infection, he was even a higher fall risk than normal. R1 was on isolation and at the end of the hall furthest away from the nurses' station which would also make his fall risk higher. V3 confirmed R1's falls with injuries might have been prevented if staff had supervised him	S9999		

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more frequently and had more fall prevention interventions in place.

The facility's Fall Prevention Program dated January 20222 documents the fall prevention program will be implemented to ensure all residents' safety in the facility. Each resident's risk for falls will be assessed and appropriate interventions in order to provide the necessary supervision and assistive devices will be implemented.

(A)

Statement of Licensure Findings 2 of 2:
300.610a)
300.1210b)
300.1210d)2)3)
300.1630d)

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

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S9999	Continued From page 7	S9999		

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:

2) All treatments and procedures shall be administered as ordered by the physician.

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 300.1630 Administration of Medication

d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

These Regulations are not met as evidenced by:

Based on interview and record review the facility failed to administer ordered and available respiratory nebulizer treatments for a resident (R2) who requested treatment while experiencing a Chronic Obstructive Pulmonary Disease

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S9999	Continued From page 8 (COPD) exacerbation. This failure resulted in R2 being transferred to the Emergency Room (ER) to receive treatment. R2 is one of three residents reviewed for a delay in care in the sample of three. Findings include: R2's Minimum Data Set dated 8/19/22 documents R2 is cognitively intact. R2's Physician Order Sheet, dated September 2022, documents an order for Albuterol Sulfate Nebulization Solution 0.083% (2.5 milligram/3 milliliters) 2.5 milligrams inhale orally via nebulizer every four hours as needed for wheezing. On 9/26/22 at 10:59 AM R2 stated on the early morning hours of 9/20/22, she was short of breath. She knew she was having a COPD exacerbation. She asked for a nebulizer treatment at about 7:30 AM. She had one she could have as needed per the doctor orders. However, the nurse, V13 Licensed Practical Nurse/LPN wouldn't give her the nebulizer treatment. V13 stated she couldn't because it was against the facility's Covid policy. V13 told R2 to take her other medications and inhalers and rest and see if that helped. R2 told V13 it wouldn't help enough but V13 didn't listen. At 9:00 AM R2 went to the nurse's station and V13 was just sitting there. R2 told V13 if she didn't call the ambulance R2 was going to call them herself. R2 stated she was tired of waiting for V13 to do something to help her. Finally, V13 got on the phone and called Emergency Medical Services and they took R2 to the ER. R2 was given oxygen and nebulizer treatments and stated she felt better. R2 stated she felt helpless and the fact that V13 LPN, the nurse in charge of her care,	S9999		

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wasn't willing to give R2 a nebulizer treatment made her feel very anxious and scared that V13 would just let R2 get worse and worse. R2 stated she felt neglected and like no one cared.

R2's Nurses Note dated 9/20/22, written by V13 Licensed Practical Nurse documents R2 was complaining of shortness of breath and requesting a nebulizer treatment. V13 told R2 that due to Covid the facility doesn't administer nebulizer treatments. R2 requested to go to the Emergency Room. Emergency Medical Services were called and R2 was transported to the Emergency Room for evaluation.

R2's Emergency Medicine Record dated 9/20/22 documents R2 arrived in the ER with shortness of breath. R2 has a history of COPD. R2 stated facility V13 LPN would not give R2 her prescribed nebulizer treatment and R2 feels she was being neglected. ER pulmonary assessment showed expiratory wheezing and shortness of breath.

On 9/27/22 at 2:58 PM V9 Infection Preventionist Registered Nurse confirmed R2 had an order for a nebulizer treatment PRN (as needed) for wheezing and if R2 stated she was short of breath and needed the medication, V13 LPN should have given it to R2. V13 did not follow physician orders and did not provide treatment to R2 when needed/requested. V13 was terminated for this reason.

V13's LPN Termination/Resignation record dated 9/21/22 documents V13 was terminated by the facility for a "violation of policy."

On 9/28/22 at 1:52 PM V3 Medical Doctor confirmed R2 had a PRN (as needed) nebulizer treatment ordered, and the nurse (V13 LPN)

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S9999	Continued From page 10 should have given it to R1 if she requested it due to respiratory symptoms from a COPD exacerbation. The nurse should have not withheld the treatment. (A)	S9999		