		AND HUMAN SERVICES			FORM	10/30/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
146017			B. WING	IG	05/3	0/2012
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HERITAGE REHAB & HC				1315B CURT DRIVE CHAMPAIGN, IL 61820		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	facility Q/A Action P the facility had idem E1 produced blank Correction and Folk 11:55am stating the E1 stated, "I have ju using them. Right r narrative form in ou The facility was una to demonstrate they developed and impl action steps (includ policy), and evaluat for the areas of non the survey: resident ulcers, and restorat The Centers for Me form 672 "Resident Residents" complet census of 55 reside FINAL OBSERVATI LICENSURE VIOL 300.1210a) 300.1210b) 300.1210b) 300.1210d)3)6) 300.1220b)2)3) 300.3240a) Section 300.1210 G Nursing and Persor a) Comprehensive with the participatio	Plans for any areas of concern tified in the past 12 months. forms titled "Plan of ow-Up Record" on 5-23-12 at ese were his action plan forms. ust been instructed to start now we put our action plans in ar Q/A minutes." able to provide documentation y had identified problems, lemented corrective goals and ding staff training or revision of ted effectiveness of changes in compliance identified during t falls, restraints, pressure tive nursing programs. edicare and Medicaid Services, t Census and Conditions of ted on 5-16-12 reflects a ents. IONS ATIONS	F 5	520		

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DEPART CENTER	PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391						
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146017	B. WI	NG _		05/30	0/2012
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HE	ERITAGE REHAB & H	с			1315B CURT DRIVE CHAMPAIGN, IL 61820		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	applicable, must de comprehensive carr includes measurabl meet the resident's and psychosocial me resident's comprehe allow the resident to practicable level of provide for discharg restrictive setting bar needs. The assess the active participat resident's guardian applicable. (Section b) The facility shall and services to atta practicable physical well-being of the resident's com plan. Adequate and care and personal of resident to meet the care needs of the resident to subsis- care shall include, a and shall be practic seven-day-a-week I 3) Objective observi- resident's condition emotional changes determining care re- further medical eva made by nursing sta- resident's medical re-	evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which o attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care ment shall be developed with tion of the resident and the or representative, as n 3-202.2a of the Act) provide the necessary care ain or maintain the highest l, mental, and psychological sident, in accordance with nprehensive resident care l properly supervised nursing care shall be provided to each e total nursing and personal esident. Section (a), general nursing at a minimum, the following eed on a 24-hour, basis: vations of changes in a d, including mental and d, as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the	F9	999			

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DEPART CENTE	PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-039						
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		146017	B. WI	NG _		05/30	0/2012
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HI	ERITAGE REHAB & H	c			1315B CURT DRIVE CHAMPAIGN, IL 61820		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	as free of accident I nursing personnel s that each resident r and assistance to p Section 300.1220 S Services b) The DON shall s nursing services of 2) Overseeing the o the residents' needs defined conditions a sensory and physic status and requirer discharge potential, potential, rehabilitat and drug therapy. 3) Developing an up each resident based comprehensive ass and goals to be acco and personal care a representing other s activities, dietary, and are ordered by the p the preparation of th plan shall be in writt modified in keeping indicated by the ress shall be reviewed a Section 300.3240 A a) An owner, licenso	hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents. Supervision of Nursing supervise and oversee the the facility, including: comprehensive assessment of s, which include medically and medical functional status, cal impairments, nutritional nents, psychosocial status, dental condition, activities tion potential, cognitive status, p-to-date resident care plan for ed on the resident's sessment, individual needs complished, physician's orders, and nursing needs. Personnel, services such as nursing, and such other modalities as physician, shall be involved in he resident care plan. The ting and shall be reviewed and g with the care needed as sident's condition. The plan at least every three months	F9	999	ε		

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		AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
( ) -		IDENTIFICATION NUMBER:	(A. BUI			COMPLETED	
		146017	B. WI	√G		05/30/2012	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HE	ERITAGE REHAB & H	с			315B CURT DRIVE CHAMPAIGN, IL 61820		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	These requirements by: Based on observati review, the facility facircumstances relat assess the risk for e of an air flow mattree four residents (R13) sample of 14. Thes risk for further falls strangulation, or sur lodged between the Findings include: R13's Physician Ore 2012 documents the Dementia, Left Bell Cerebral Vascular A and Severe Periphe R13's Minimum Dat and 03/12/12 docur cognitively impaired extremity range of lower leg's range of is unable to balance and requires extens mobility. R13's Interim Care documented R13's	s were not met as evidence ion, interview, and record ailed to thoroughly investigate ted to a fall and failed to entrapment and falls in the use ess and side rails for one of ) reviewed for side rails in the e failures put the resident at with injury and entrapment, ffocation if she became e mattress and the rails. der Sheet (POS) dated May e following diagnoses: ow the Knee Amputation, Accident, Gastrostomy Tube, eral Vascular Disease. ta Set (MDS) dated 09/26/11 ment that R13 is severely d, has no impairment of upper motion, has impairment of one f motion (due to amputation), e without human assistance, sive assistance with bed all Risk Assessment dated s that R13 was at high risk for Plan dated 09/14/11 high risk for falls but did not	F99	999	DEFICIENCY)		
		ty precautions to be					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	10/30/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146017	B. WIN	G		05/30	0/2012
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HI	ERITAGE REHAB & H	С		-	B15B CURT DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	implemented by sta of assistance requir transferring. The Investigation R documents that on found lying on her le in pain with any boo pool of blood." The Emergency De 09/18/11 document to the left temporal On 05/22/12 at 12:0 Nurse (LPN), stated responded to R13's were raised on the E10 confirmed this 3:50pm. The Investigation R fails to document us R13's fall, but does interventions to be checks, side rails, a low bed." The Invest documents the root "Resident attempted unaware of her limit On 05/22/12 at 4:16 stated that R13's fal hallucinating and try	Aff, nor did it direct the extent red for R13's bed mobility or Report for Falls dated 09/18/11 09/18/11 at 2:15pm R13 was left side on the floor, "left arm eft side of her body, screaming dy movement, and head in a epartment Report dated ts that R13 received 15 sutures laceration. 05pm, E10, Licensed Practical d that on 09/18/11 when she s fall, bilateral full side rails bed with the air flow mattress. statement on 05/22/12 at Report for Falls dated 09/18/11 se of side rails at the time of a document the following implemented: 15 minute and "family requested possibly stigation Report for Falls t cause of the fall to be ed to change position and was itations." 6pm Z1, family member, all was caused by R13 ying to feed her dog. Z1 stated lge side rails were not being	F99	99			

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DEPARTM CENTERS	PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-039						
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146017	B. WI	NG		05/30	0/2012
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HER	RITAGE REHAB & HO	C			315B CURT DRIVE CHAMPAIGN, IL 61820		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
T aa F O kaa c S ar; n ir O S b r; S o O a ly b u c M c o e o	and R13's MDS dat R13's hallucination. On 05/22/12 at 1:05 eft stump, and both n bed. The Facility investig knowledge of R13's ability of R13's purp appropriateness of conjunction with an Side Rail Assessme and 03/13/12 do no rails in conjunction with mattress. Use of the mplemented. On 05/15/12 at 1:00 standard height bec pilateral three-quart rails extended from side rails extended from side	Soperation for Falls dated 09/18/11 and 09-26-11 do not document for R13 raised her right leg, in arms upon command while gation failed to demonstrate is hallucinations, an assessed boseful movement, and the R13's full side rails used in alternating air mattress. The ents dated 09/13/11, 09/19/11, t address the use of full side with an alternating air e low bed was not Dpm R13 was lying on a d on an air flow mattress with ter side rails in use. The side R13's axilla to her ankle. The four inches above the height Sopm, the foot and head of the empressed (with the resident the bottom structure of the four and one-half inches is compressible space was /12 at 2:00pm with E5, rvisor. Including this e and the four inch extension ove the mattress, there is an ench space along the side rails is bed in which R13 could be	F9	9999			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER.	A. BU	LDIN	IG	COMPLE	IED
		146017	B. WI	NG		05/30	0/2012
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HE	ERITAGE REHAB & H	C			CHAMPAIGN, IL 61820		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 84	F99	999			
	cause entrapment of head, neck, or ches mattress, or spaces	space has the potential to or wedging of R13's limbs, at between rails and the between side rails and the ad and cause serious injury or					
	was positioned to h	Opm and 3:30pm when R13 er right and left sides, there ween R13, the rail, and the entrapment.					
	3:45pm, there was	5am, 11:15am, 1:30pm, and no padding between R13, the as to prevent entrapment.					
		am, 12:00pm, and 1:30 pm, ng between R13, the rail, and vent entrapment.					
		opm there was no padding ail, and the mattress to 					
	she had the ability t stump, and both arr The four inches the the mattress could	opm R13 demonstrated that o raise her right leg, left ns (purposeful movement). raised side rails extend above enable R13 to place her leg on the side of the bed onto the self.					
	circumstances relat failed to assess and entrapment and fall	ed to thoroughly investigate ed to a fall with injury and d mitigate the risk for s in the use of an air flow ails for R13, who was					

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		AND HUMAN SERVICES				FORM	: 10/30/2012 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED
146017			B. WI	ING _		05/3	0/2012
NAME OF F	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
ILLINI HI	ERITAGE REHAB & H	С			1315B CURT DRIVE CHAMPAIGN, IL 61820		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ao 95					
1 3333	-	fall risk on admission	ГЭ	999	)		
		(A)					

Facility ID: IL6004212