		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
STATEMENT OF DEFICIENCIES(X1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С	
145439		B. WING	;		03/12/2013		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
СНАМРА	IGN URBANA NRSG	& REHAB			302 WEST BURWASH		
					SAVOY, IL 61874		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG			TAG	;	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
			1				
F 323	Continued From pa	ae 2	F (	323	3		
	•	m E6 acknowledged that she					
	was coming down t	he hall with another resident in					
		n she heard R5's voice in the nought"Oh she's in the					
		wondered what shower chair					
	she was using since	e I had the only one for that					
		oom." E6 stated she then					
		nd went to the shower room to and E9 leaning over her. E6					
		are aware that the backless					
		e not to be used on the					
		ng showers. "They are used to nes on. We all know residents					
		m during a shower and (E9)					
	used the wrong cha	ir because she did not want to					
F9999	wait for the right one FINAL OBSERVAT		F99	000			
L9999	FINAL ODSERVAT	10113	г9:	995			
	LICENSURE VIOL	ATIONS <sup>.</sup>					
	200 4040->						
	300.1210a) 300.1210b)						
	300.1210d)6)						
	300.3240a)						
	Section 300.1210 G	General Requirements for					
	Nursing and Persor						
	a) Comprehensive	Resident Care Plan. A facility,					
		n of the resident and the					
	resident's guardian	or representative, as					
		velop and implement a					
		e plan for each resident that le objectives and timetables to					
		medical, nursing, and mental					
		eeds that are identified in the					

Facility ID: IL6001457

If continuation sheet Page 3 of 7

PRINTED: 07/09/2013

	-	I AND HUMAN SERVICES					FORM	07/09/2013 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G		(X3) DAT COM	E SURVEY PLETED
		145439	B. WING	€				C 12/2013
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, Z	IP CODE		
CHAMP	AIGN URBANA NRSG	& REHAB			302 WEST BURWASH SAVOY, IL 61874			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD	BE	(X5) COMPLETION DATE
F9999	allow the resident to practicable level of provide for discharg restrictive setting baneeds. The assess the active participat resident's guardian applicable. (Section b) The facility shall and services to atta practicable physica well-being of the re each resident's com plan. Adequate and care and personal of resident to meet the care needs of the re d) Pursuant to subs care shall include, a and shall be practic seven-day-a-week 6) All necessary pre assure that the resi as free of accident nursing personnel s	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 a 3-202.2a of the Act) provide the necessary care an 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 sed on a 24-hour, basis: ecautions shall be taken to dents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision prevent accidents.	F9	999	9			

If continuation sheet Page 4 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLI				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145439	B. WING			C 03/12/2013	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		2,2010
CHAMPAIGN URBANA NRSG & REHAB				-	02 WEST BURWASH GAVOY, IL 61874		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 4	F99	999			
	a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)						
	These requirement	s are not met as evidenced by:					
	to use a shower cha	view and interview, staff failed air with a back, when bathing nts (R5) reviewed for falls in a failure resulted in R5 falling actured hip.					
	Findings include:						
	list diagnoses of D Scoliosis. The Minin 2/19/13 documents impairment. The Mi status as not stead staff assistance wh standing, moving of surface transfer. RS 2013 documents th to be used during b	er Sheet dated February 2013 ementia and Idiopathic mum Data Set (MDS) dated R5 with severe cognitive DS documents R5's functional y and only able to stabilize with en moving from seated to n and off toilet and surface to 5's Care plan dated February at a reclining shower chair is athing. The Fall Risk February 2013 assesses R5					
	documents R5 slid Certified Nursing As shower, no injury w Nursing Notes date document that R5 w	dated 2/19/13 at 5:50 am out of a shower chair while E9 ssistant was giving her a as assessed at this time. R5's d 2/19/13 at 10:30 am vas not able to bear weight on mplained of pain. R5 was					

If continuation sheet Page 5 of 7

PRINTED: 07/09/2013

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	TE SURVEY MPLETED C 5/12/2013
	8/ <b>12/2013</b> (X5)
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE	
CHAMPAIGN URBANA NRSG & REHAB 302 WEST BURWASH SAVOY, IL 61874	(X5) COMPLETION
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTIONPREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)IDPREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F9999       Continued From page 5       F9999         ransported to the hospital. The hospital notes for R5 dated 2/19/13 document under Assessment - Right Subcapital Femoral Head Fracture with some displacement. Plan - Admit to hospital with Right Hip Hemiarthroplasty 2/20/13.       F9999         The facility's investigation (of R5's fall of 2/19/13) is dated 2/20/13 and documents an interview with E6, Certified Nursing Assistant stating that she had been coming down the hall at the time of R5's shower and heard a thud (like a boom) and heard R5 calling for help. E6 stated that she looked in the shower room and saw R5 on the floor and E9 standing over R5. An investigation interview by the facility dated 2/21/13 documents E8, Licensed Practice Nurse stating that E9 had used a shower bench instead of a shower chair while giving R5 a shower.         On 3/1/13 at 11:50 am E1, Administrator stated that E9 had used due down the able that be had used a chair with a back, but the facility fall investigation revealed that a bench without a back was used during R5's shower. E1 stated that she had used a chair with a back, but the facility fall investigation R5's shower. E1 stated that since false information was given by E9 and E9's actions of using an unsafe chair caused injury to R5, E9 was terminated.         On 3/8/13 at 2:45 pm E6 acknowledged that she was coming down the hall with another resider in the shower room and thought'On she's in the shower room, and I wondered what shower chair she was using since I had the only one for that particular shower room." E6 stated she then head a loce of that and head rower room in to the shower room in to the shower room in to the shower room in the shower room in the shower room in to make the shower room in the shower room in the shower room in to the shower room in to to the shower room in to the shower room i	

If continuation sheet Page 6 of 7

		I AND HUMAN SERVICES				FORM	: 07/09/2013 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
145439		B. WING	3 <u> </u>		C 03/12/2013		
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 302 WEST BURWASH		
СНАМРА	IGN URBANA NRSG	& REHAB			SAVOY, IL 61874		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	stated that the staff shower benches ar residents while givin put towels and cloth are not to be in ther	and E9 leaning over her. E6 are aware that the backless e not to be used on the ng showers. "They are used to hes on. We all know residents m during a shower and (E9) air because she did not want to	F9	999			

Facility ID: IL6001457

If continuation sheet Page 7 of 7