STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. BUILDING _____ B. WING _____	C 12/13/2015

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

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1566710/IL82029	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1	F 272		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to perform a comprehensive resident assessment for one resident (R1) out of three residents reviewed for assessments.

Findings include:

The facility's Nursing Progress Notes dated 10/14/15, 10/16/15, and 10/22/15, as well as Hospital History and Physical dated 9/28/15, documents R1 was originally admitted to the facility on 10/14/15 following a fall experienced at home on 9/24/15 which resulted in a fractured femur and a surgical repair at the hospital. Additional medical diagnoses include Anemia, Diabetes, Hypertension, and Cerebrovascular Disease.

On 12/10/15 at 12:10 pm, E2, Director of Nursing, provided a blank Admission Assessments Nursing Management Check List which documents, inclusively, that a fall risk assessment is to be completed for each resident admitted to the facility.

On 12/10/15 at 12:10 pm E3, Director of Nursing, stated, "We do not have a completed Admission Assessment Checklist for (R1)."

The facility did not provide any documentation to show they completed a fall risk assessment for R1 during the admission process, nor at any time

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F 272	Continued From page 2 until 11/29/15 when R1 experienced a fall in the facility. On 12/10/15 at 10:00 am E16, Minimum Data Set and Care Plan Coordinator, stated, "I do not have, or see that we have, a fall risk assessment for (R1) prior to 11/29/15." On 12/10/15 at 12:10 pm E3, Director of Nursing, stated, "I could only look in the same places you have already looked, unless our corporate can pull it up, but I can't. What is on the computer is going to be all we have." On 12/10/15 at 1:10 pm, E7, Corporate Representative, stated, "We do not have a fall risk assessment for (R1) prior to 11/29/15."	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		

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F 279	Continued From page 3 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to initiate an initial/interim care plan, and failed to formulate a comprehensive care plan based on the Resident Assessment Instrument for one resident (R1) out of three residents reviewed for care plans. Findings include: The facility's progress notes document R1 was admitted to the facility on 10/14/15 after experiencing a fall at home which resulted in a fractured femur. The fracture was surgically repaired at the hospital prior to R1's admission to the facility. The Physical and Occupational Therapy Notes for R1 dated 10/15/15 document R1 required 50 percent weight bearing assistance with activities of daily living such as transfers, toileting, ambulation, dressing the lower body, and bathing the lower body, due to a weight bearing restriction on the right leg following the surgical repair of the fracture experienced prior to admission. The facility did not provide any documentation to show that they had initiated an initial/interim care plan for R1's needs for assistance in activities of daily living. The facility's initial Minimum Data Set for R1 dated 10/21/15 documents Care Area Assessment Triggers for seven care areas.	F 279		

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F 279	Continued From page 4 Documented care areas included; 5) ADL (activities of daily living) Functional/ Rehabilitation Potential, 6) Urinary Incontinence and Indwelling Catheter, 7) Psychosocial Well-Being, 10) Activities, 11) Falls, 12) Nutritional Status, and 16) Pressure Ulcer. Each of these areas was marked by the facility as "proceed to care plan." On 12/10/15 at 8:00 am, R1's care plan only included two care areas. These areas were; 1) a discharge plan initiated 10/22/15 for when R1 would be ready to return home, and 2) a fall care plan initiated 11/29/15 after R1 experienced a fall at the facility. On 12/10/15 at 10:00 am E16, Minimum Data Set and Care Plan Coordinator, stated, "I do not have, and I don't see that we have, an initial/interim care plan for R1." On 12/10/15 at 12:10 pm, E3, Director of Nursing, stated, "I could only look at what you have already looked at (care plan and care plan history), unless our corporate representative can pull it up, but I can't. As of right now, what we have on the computer is all we have." On 12/10/15 at 1:10 pm E7, Corporate Representative, stated, "We do not have an initial/interim care plan for R1." E7 stated, "The care plan and care plan history is not retrievable for R1, even from my computer, but it should be if it was there."	F 279		