STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145439	A. BUILDING _____ B. WING _____	**03/04/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the physician of an unplanned significant weight gain for one of three residents (R1) reviewed for weight gain on the sample of three. Findings include: R1's weight printout sheet documents R1 was admitted to the facility at a documented weight of 130 pounds on 2/1/20. This sheet documents on 2/2/20 R1 weighed 140.3 pounds, on 2/3/20 R3 weighed 141 pounds, and on 2/17/20 R1 weighed 158.3 pounds. On 3/2/20 at 11:30 am V3(Director of Nursing) stated that they weigh new admits for three days after admission and then weekly. The Certified Nursing Assistants are supposed to report the weights to the nurse. Three pounds in a day or five pounds in a week would be a significant weight change. The physician should have been notified of the weight gain. It would not flag anywhere. On 3/3/20 at 2:37 pm V13(Minimum Data Set Coordinator) stated that once the Certified Nurse Aide gets the weight, it is supposed to be given to the nurse for the Electronic Medication Administration Record. V13 stated that V13 did not see it documented on the Electronic Medication and Administration Record. The nurse is supposed to document it there to see a weight gain or loss and notify the physician. On 3/4/20 at 10:00 am V4 Nurse Practitioner, stated that V4 would have expected the staff to notify her of any weight gain or loss of 3-5 pounds so that V4 could have ordered reweighs and potentially changed the medical treatment orders. V4 stated that had this occurred, it could have potentially affected R1's [DIAGNOSES REDACTED].
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview, and record review, the facility failed to operationalize their abuse prevention policy by failing to follow their investigation procedures for an allegation of physical abuse for one of three residents (R1) reviewed for physical abuse on the sample of three. Findings include: The facility's Abuse Prevention Program dated November 2017 documents, 4. Investigation Procedures. The appointed investigator will, at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. The facility's Final Incident Investigation Report dated 2/27/20 documents an allegation of physical abuse. This report documents R1's family member (V17) reported R1 as having a new leg fracture, bruises to the right arm, and a thirty pound weight gain. This report does not document that any of the staff taking care of R1 was interviewed and does not document V17 was interviewed. On 3/2/20 at 1:19 PM, V1 Administrator stated V1 did not talk to any of R1's direct care staff or V17 during the investigation of R1's alleged physical abuse.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to conduct a thorough abuse investigation for one of three resident (R1) reviewed for physical abuse on the sample of three. Findings include: The facility's Incident Investigation Report dated 2/27/20 documents that an allegation of physical abuse was made by V17 (R1's family member). This report documents V17 came into the facility on [DATE] and made an allegation to V5 Guest Relations that R1 had a new fracture, bruising to the right arm, and a 30 pound weight gain. On 3/2/20 at 1:19 PM, V1 Administrator stated V1 did not talk to any of the direct care staff who took care of R1. V1 stated V1 did not talk to V17 who made the allegation of physical abuse. V1 stated V1 did not know if R1 had a new fracture and V1 had not talked to R1's orthopedic surgeons. V1 stated V1 concluded the investigation and sent the final investigation in on 2/27/20. R1's face sheet documents R1 was admitted to the facility on [DATE]. This sheet documents R1 as having a [DIAGNOSES REDACTED]. On 3/3/20 at 9:34 AM, V17 (R1's Family Member) stated after V17 talked to V5 no one at the facility called V17 about R1's injuries. V17 stated someone at the facility left a message on 3/2/20 for V17 to call them back. The facility's staffing sheets dated 2/2/20 through 2/20/20 documents the following Certified Nursing Assistants (CNA) provided direct care to R1: V7, V8, V18, V19, V20,V22, V23, V24, V25, V26, V27, V28, V29, V30, V31, V32, V33, V34, V35, V36, V37, and V38. The facility's staffing sheets dated 2/2/20 through 2/20/20 documents the following Registered Nurses provided direct care to R1: V39, V41, V42, and V44. The facility's staffing sheets dated 2/2/20 through 2/20/20 documents the following Licensed Practical Nurses provided direct care to R1: V9, V11, V49, V45, V46, and V43. On 3/3/20 to 3/4/30 between the hours of 9:00 AM and 3:30 PM, V8, V9, V18, V19, V22, V24, V25, V28, V30, V32, V34, V35, V38, V39, V41, V42, V44, V45, V46 all stated they had worked with R1 and that no one at the facility (administratively) had talked to them to ask about R1's alleged bruising, new fracture, or weight gain between the dates of 2/25/20 through 2/27/20. On 3/4/20 at 9:17 AM, V48 Orthopedic Surgeon stated, I did a half a hip replacement for (R1) for a fractured femur (on 1/28/20). The greater trochanter was intact. When (R1) came back (2/21/20) the greater trochanter had fractured. The x-rays on the 28th (1/28/20) show there is no fracture and then on the 21st (2/21/20) there is a fracture to the greater trochanter. No one at the facility has called to ask me about the fracture.

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.