STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005953	A. BUILDING: _____ B. WING _____	C 03/16/2021

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TAYLORVILLE SKLD NUR & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

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S 000	Initial Comments Complaint Investigation #2141465/IL131501	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.610a) 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. 300.1210b) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 measures shall include, at a minimum, the following procedures: 300.1210d)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 and assistance to prevent accidents. These Regulations were not met as evidenced by: Based on observations, interviews and record review, the facility failed to develop and implement progressive interventions to prevent falls, provide supervision for those at risk for falls and provide safe transfer techniques to prevent injuries for 5 of 10 residents (R5, R6, R23, R24 and R25) reviewed for supervision to prevent fall/accidents in the sample of 10. This failure resulted in R24 falling and sustaining a left hip contusion and left 8th rib fracture. Findings include: 1. R24's Face Sheet, undated, documented he had a diagnosis of dementia. R24's MDS dated 1/26/2021 documents that R24 requires extensive physical assistance of one staff person for transfers, walking in room and corridor and toileting. The MDS documents R24 is not steady and requires staff assistance to stabilize when turning around, moving on and off toilet. from a seated to standing position and walking.	S9999		

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S9999	Continued From page 2 R24's Care Plan, initiated on 8/26/19, documents he needs limited to extensive assist of staff related to weakness, decreased mobility, poor balance and impaired cognition and the inability to recognize his physical limitations. The Care Plan interventions, initiated on 9/4/19, documents "Transfer: One person physical assistance required; Ambulation-to and from bathroom with gait belt, front wheeled walker and assist of one or two; Toilet Use- One to two physical assist required due to weakness and poor balance." R24's Care Plan, initiation dated 8/26/19, documents "At risk for falls and injuries due to weakness, poor balance, impaired cognition and lacking safety awareness, Zoloft use, will try and self transfer, will refuse assist with toileting or go when offered at times and to lay down in bed in the afternoon when tired." R24's Situation, Background, Assessment, Recommendation (SBAR) form, dated 1/31/2021, documents R24 was getting up from toilet with unsteady gait. Briefly describe the nature of occurrence: Resident found on floor sitting on buttocks in front of toilet. Assisted up and into wheelchair no injuries noted. R24's Care Plan Intervention, dated 1/31/21, documents "Staff educated to stay with resident while on toilet." R24's SBAR, dated 2/14/21, documented on 2/14/21 at 6:50 PM, "Writer heard yelling while in the middle of med pass, went looking around to see who and what it was walked past resident room and see resident sitting on the floor legs out in front of him leaned up against the w/c. left arm bleeding. Roommate state resident tried to stand up and feet slid out and he fell on his bottom.	S9999		

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S9999	Continued From page 3 Resident and roommate denied hitting of head." The SBAR documented "Resident is very impatient when it comes to bed. CNAs were 3 doors down working their way to him. Writer informed resident he needed to wait for the girls to help him in bed." The SBAR documented "Root Cause: Resident attempted to self transfer from wheelchair to bed. Interventions: Resident encouraged to be in common area until staff assist to bed. Resident states he prefers to go to bed around 7pm." R24's General Note, dated 2/14/21, documented "Resident did receive a skin tear to his left forearm, measures 4 cm (centimeters) x (by) 0.5 cm and couple small non measurable areas around the main area." There was no documentation, R24's Care Plan was not updated with new interventions to address his fall on 2/14/21 or to prevent him from future falls. R24's General Note, dated 2/17/2021 at 10:59 AM, documents "Writer was called to resident's room to assess resident post fall. Resident was laying on his L (left) side in the BR (bathroom). Denies pain and hitting his head. Able to move all extremities w/o (without) issue. Able to bear weight on BLE's (bilateral lower extremities). New skin tear noted to L (left) elbow. Area was cleansed and steri strips applied. Resident did have tennis shoes on. Call light was not on. Resident was sitting on the toilet, the aide had went to get wash cloths and resident was trying to self-transfer back to w/c. MD and POA (power of attorney) made aware. Aides were educated that resident is to no longer be left unattended while in BR (bathroom)."	S9999		

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S9999	Continued From page 4 R24's Care Plan, revised on 2/17/21, documented "Staff education. Resident not to be left unattended in bathroom." R24's Unwitnessed fall investigation dated 2/18/2021 documents "Resident observed ambulating in room without assist just as resident fell onto his left side on floor in doorway of room." The Investigation documented "Root Cause "resident ambulating without staff assistance. Interventions: New order for UA (urinalysis) and labs obtained due to actions/behaviors that are unusual for resident." R24's General Note, dated 2/23/2021, "Writer called PCP (Primary care physician) to notify about left pupil at a 4 and right eye is pinpoint. PCP would like him to be sent out due to recent falls." R24's General Note, dated 2/23/2021, documents "Resident returned from (local hospital) to facility at approximately (10:10 PM) via ambulance. CT (Computed Tomography) and X-Rays performed. NNO (no new orders). fx (fracture) to left rib. contusion to left hip. no other injuries noted." R24's Emergency Room Report, dated 2/23/21, documents R24 had a fall 5 days prior. The ER Report documented an x-ray was taken and R24 sustained a left 8th rib fracture. The ER Report Clinical Impression documents "1. Single left rib fracture; 2) Single contusion to left hip; and 3) Fall." On 3/8/2021 at 12:12 PM, V23, Physical Therapist Assistant/PTA, stated R24 uses a walker with a sit to stand and always with staff assistance.	S9999		

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S9999	Continued From page 5 On 3/16/2021 at 11:15 AM, V12, LPN stated, "No, staff should not leave (R24) alone on toilet." V12 stated that R24 would transfer himself from the toilet at times. V12 stated that staff does have to assist R24 with transfers. On 3/16/2021 at 2:20 PM, V26, Nurse for V24 (R24's Physician), stated "Someone needs to be with (R24) while he is on the toilet." 2. R23's Physician's Order Sheets from 2/2/21 through 3/4/21 documents R23 has diagnoses of dementia and history of falling. R23's Fall Risk assessment dated 2/2/2021 documents that R23 is at high risk for falling. R23's MDS dated 2/8/2021 documents R23 requires extensive assistance from 2-persons for ambulation in room. The MDS documents he requires extensive physical assistance of one staff for locomotion on unit and one-person physical assistance for toilet use. R23's MDS also documents his balance is not steady when moving from seated to standing positions, walking, turning around, moving on and off toilet and surface-to-surface transfers. The MDS documents he is only able to stabilize with staff assistance. R23's Care Plan dated 2/2/2021 documents R23 has self-care deficit as evidence by needing assistance with Activities of Daily Living (ADLS) related to dementia, impaired decision-making, recent infection and history of falls. The Care Plan Intervention, dated 2/2/21, documented "Transfer: One-person physical assistance required." The Care Plan Intervention, dated 2/2/21, documents "Toilet Use: One-person physical assist required." R23's Care Plan,	S9999		

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initiated on 2/2/21, documents R23 is at risk for falls related to medication use and medical factors.

R23's Unwitnessed fall investigation dated 2/3/2021 documents "Writer heard a noise from resident's room entered room observed resident sitting on floor next to recliner and bed. Resident sitting upright holding onto siderail of bed and arm of recliner, states 'I fell'. Writer asked resident what he was doing he stated he was trying to move the cord to the IV pump around the bed. The Investigation documents "Root cause: Resident states he was attempting to move power cord to IV pump around the bed." The Intervention documents "Staff to place power cord behind bed or recliner."

R23's Care Plan Intervention, revised on 2/4/21, documents staff would place power cord behind bed or recliner.

R23's Unwitnessed fall investigation dated 2/4/2021 documents, "Staff passed by resident's room at approximately (5:00 AM) and observed resident sitting on floor next to recliner on buttocks. Resident had IV pole tipped over. Resident wearing nonskid socks." The Investigation documents "States he doesn't know why he was trying to get up." The Root Cause on the Investigation documents "Resident attempted to transfer self from bed without assist." The Intervention documents "Tab alarm when in bed or recliner."

R23's Care Plan Intervention, revised on 2/4/21, documents "Tab alarm placed due to confusion and anxiety leading to falls."

R23's Situation Background Assessment

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Recommendation (SBAR), dated 2/12/21 documents R23 fell on 2/12/21 at 10:30 PM. The SBAR documents "Heard loud crash, writer ran down to resident room, resident sitting on floor legs out in front of him towards the bed. When writer asked resident what happened resident state 'I slipped, but I'm fine.'" The SBAR documented "Root cause: Resident attempted to self transfer and lost balance due to weakness and lack of activity tolerance. Intervention: Call don't fall sign placed in room and discussed with resident."

R23's General Note, dated 2/12/21at 10:40 PM documents "Roommate stated he (R24) did not hit his head and he went to stand up and just fell down."

R23's Care Plan Intervention, dated 2/12/21 documents "low bed."

R23's Unwitnessed fall investigation dated 2/16/2021 documents "Writer entered room observed resident sitting on floor in front of WC on buttocks. Resident states he slipped so he pulled himself out of chair using bed rail. Alarm not sounding, call light not activated." The Investigation documented "Root cause: Resident states he was slipping out of chair and grabbed bedrail to pull himself up. Intervention: Pressure alarm applied to wheelchair."

R23's Care Plan Intervention, revision dated 2/16/21, documented "Pressure alarm applied to wheelchair."

R23's Unwitnessed fall Investigation dated 2/18/2021 documents "Writer walking down hallway and observed resident sitting on floor between wall and bed. Resident states he was

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trying to go home. Resident has removed all clothing and slipper socks, had removed his alarm, and had it hidden under blankets and pillows. Resident had used his bed remote and raised bed into air, as staff had bed in low position." The Investigation documents "Resident assisted X 2 staff to w/c and brought to nurses' station for observation." The Investigation documented "Tab alarm removed and replaced with pressure alarm. Bed remote to be placed out of reach after resident is assisted to bed and positioned to his liking."

R23's Care Plan Intervention, revision date 2/18/21, documents "Tab alarm removed and replaced with pressure alarm. Bed remote to place out of reach after resident is assisted to bed and positioned to his liking."

R23's Care Plan, initiation date 2/19/21, documents, "This resident has a behavior problem (will remove alarm and shut off) r/t (removes safety devices." The Interventions, dated 2/19/21, documented to administer medications as ordered, anticipated the meet the residents needs and explain all procedures prior to implementation.

R23's Unwitnessed fall investigation dated 2/22/2021 documents "Staff walking by resident's room and observed resident sitting on floor next to roommate's bed. Resident had disabled his alarm. Bed was in low position. Resident had removed clothing and gripper socks. Resident had knocked over IV pole." The Investigation documented "Intervention: large surface area pressure alarm applied to bed."

R23's PT daily treatment note dated 2/25/2021 documents "Writer instructed in gait training with

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ptnt (patient) only ambulation x15 feet with moderate assistance and close wheelchair follow. Writer provided maximal verbal prompts to keep stance within BOS (base of support) of AD (assistive device) and to shift weight forward due to strong posterior lean. (R23) bearing weight through heels and keeping toes off of floor despite maximal cues and education. (R23) had little to no corrections despite maximal verbal cues and educations being provided.

On 3/8/2021 at 12:10 PM V8, Physical Therapist, stated that R23 fell a lot at night or early in the morning. V8 PT stated that R23 was max assist when contact made.

3. R25's Face Sheet, undated documents R25 has diagnoses of Bipolar Disorder, Dementia with Behavior Disturbance and Alzheimer's disease with early onset.

R25's MDS dated 1/19/2021 documents R25 has severely impaired cognition, requires extensive assistance of one staff person for transfers and toilet use. The MDS documents he is not steady when moving from seated to standing position, walking, turning around, moving on and off toilet and surface-to-surface transfers but is able to stabilize without staff assistance.

R25's Care Plan, initiated on 2/23/20, documents he is at risk for fall related to medications, weakness, unsteady gait balance and cognitive issue.

R25's Fall Investigation dated 1/5/2021 documents "Resident ambulating in room without walker, lost balance and fell to floor onto buttocks." The Investigation documented he sustained a skin tear to the back of his right hand.

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R25's Care Plan Intervention, revision 1/7/21, documents "Sign placed in room to remind resident to use walker, room cleaned and free of clutter. Staff educated on removal of dishes after meals."

R25's Unwitnessed Fall Investigation dated 1/6/2021 "Facility staff heard a loud noise and went to resident's room finding resident lying at foot of bed, on his back, slipper socks on. Staff noted pool of blood under resident's head. Resident alert per baseline. States that he slipped going around the corner of bed. Resident log rolled to right side while holding head and neck and noted to have laceration to back of head with moderate to heavy bleeding."

R25's General Note, dated 1/6/21 at 9:30 PM documented that R25 fell and was found with pool of blood under head. The Note documented R25 had a laceration to the back of his head. The note documented R25 was sent to ER.

R25's General Note, dated 1/7/21 at 12:15 AM, documented he returned to the facility with six stitches and 3 staples to the back of his head.

R25's Care Plan Interventions, revision 1/7/21, documented "Telemed visit with primary MD. Psychotropic medications decreased. Labs ordered."

R25's Unwitnessed Fall investigation dated 2/10/2021 documents "Writer entered room observed resident on knees next to recliner." The Investigation documents "Root Cause: resident lacks safety awareness, cognition varies R/t his medical diagnosis. Resident reports he climbed out of recliner to 'look under there'."

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R25's Care Plan, dated 2/10/21, documents "Continue current CP (care plan) interventions." The facility did not document any progressive interventions after this fall.

R25's Unwitnessed Fall investigation dated 3/3/2021 "Writer at nurse's station heard loud noise observed resident laying on stomach by snack machine, jeans around resident's ankle. Resident was ambulating without assist."

R25's Care Plan Intervention, initiated on 3/5/21, documents "New pants elastic waist pants purchased for resident."

4. R6's MDS dated 2/2/2021 documents that R6 was admitted to facility on 11/20/2019 with diagnoses of Heart failure, Anemia and Alzheimer's. R6's MDS documents that R6 requires extensive assistance 2-person physical assistance for transfers.

R6's Care Plan dated 3/17/2020 documents R6 has self-care deficits. The Care Plan documents "Needs assistance with ADLs (Activities of Daily Living) related to pain, weakness, CHF (Congestive Heart Failure), Diabetes, anemia, arthritis in right knee, and Alzheimer's." R6's Care Plan interventions, revised on 1/8/2020, documents "Transfer: Mechanical lift required sit to stand," and "Two-person physical assist required."

On 3/5/2021 at 10:00 AM, R6 stated, "They don't get enough employees to work here." R6 stated, "If there is only 1 person, then 1 person gets me up, because I can't walk anymore." R6 stated, "That don't make sense only 1 person working." R6 was alert and oriented and answered all

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S9999	Continued From page 12 questions appropriately. On 3/8/2021 at 9:55 AM, V5, CNA and V3, Assistant Director of Nursing (ADON/LPN), were in R6's room. V5 used a mechanical lift (sit to stand) and lifted R6 from his wheelchair. V5 proceeded to take? R6 bathroom and R6 was hanging by arms, with his legs bent. R6 was unable to support his own weight. V3 stated, "Not ideal transfer. (R6) needs to be a little higher." On 3/8/2021 at 12:10 PM, V8, Physical Therapist (PT), stated, "I would have expected staff to cue resident to stand while using the sit to stand." The User Manual for 'Stand Up Patient Lift' section 4- Lifting the Patient (undated) documents, " Individuals that use the standing patient sling MUST be able to support the majority of their own weight, otherwise injury may occur." 5. R5's MDS dated 2/3/2021 documents that R5 was admitted to facility on 11/19/2020 with a diagnosis to include: Cerebral Infarction, Muscle weakness and Acute Kidney failure. R5's Care Plan, initiated on 9/19/2019, documents that R5 is at risk for falls due to weakness, medication use and history of falls. On 3/8/2021 at 7:50 AM, R5 was walking down hallway using a walker with regular socks on feet until he reached the shower room. R5 stated, "I don't dress myself. They dress me." R5 stated, "I leave the same clothes on until my next shower." On 3.8/21 at 7:55 AM, V5 stated "(R5) should be wearing non-skid socks, but he walked down here to the shower room by himself."	S9999		

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	IL6005953	A. BUILDING: _____ B. WING _____	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLORVILLE SKLD NUR & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(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) COMPLETE DATE
S9999	Continued From page 13 On 3/8/2021 at 9:10 AM, R5 was walking down hallway from shower room with walker wearing regular socks and not nonskid socks. On 3/8/2021 at 1:40 PM, V3, ADON, stated, "I would expect residents to wear non-skid socks to prevent falls." Facility's Policy and Procedure "Falls and Fall Risk, Managing" dated 2018 documents "Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall risk factors: f. footwear that is unsafe or absent e. lower extremity weakness g. medication side effects i. functional impairments In conjunction with the attending physician, staff will identify and implement relevant interventions to try to minimize serious consequences of falling." (B)	S9999		