Illinois Department of Public Health

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 10/16/2019

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
S 000	Initial Comments Complaint #1947320/IL116347	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a)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. Section 300.1210 General Requirements for Nursing and Personal Care b)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	S9999	**Attachment A** **Statement of Licensure Violations**	

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 10/16/2019

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 1	S9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
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 requirements are not met evidencded by:

Based on interview and record review, the facility failed to prevent a fall during ambulation for one of 5 residents (R3) reviewed for falls and transfers in a sample of 5. R3 falling and fracturing left hip and needing surgical repair.

Findings include:

1. The Minimum Data Set (MDS) dated 3/14/19 identifies R3 to have severe cognitive impairment and requires extensive assist of one staff for transfer and ambulation in/out of her room.

The Care Plan dated 3/13/19 documented R3 to be at risk for falls due to medications, Dementia, incontinence, the need for walker for ambulation, dizziness/vertigo, poor safety awareness and history of falls.

A Fall Risk Assessment dated 4/13/19 identifies R3 as being high risk for falls.

A SBAR (Situation, Background, Assessment and

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 10/16/2019

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 2	S9999		

Recommendations) form dated 5/15/19 entered by V3, Licensed Practical Nurse (LPN) at 8:30am, R3 "fell while ambulating from dining room chair to bedroom after breakfast. Per V6, CNA (certified nurse assistant) and V5, MDS (MDS coordinator) resident did not hit head, resident lost balance falling onto left hip. Nurse assessed resident, c/o (complained of) pain to left hip, guarding hip. Left hip slightly externally rotated." The report documents R3's fall as an "assisted ambulation" note continues that V11, Physician, was notified at 8:35am.

Nurses notes dated 5/15/19 at 10:58am document R3 was transferred on a gurney via ambulance to local acute care hospital.

The Ambulance Report dated 5/15/19 documents they arrived at the facility at 8:56am. The patient care report section of the ambulance report documents "arrived on scene found pt. (patient) in her room on her bed. Pt had bowel movement and was incontinent of urine. Staff states they did not want to move her to clean her up. Staff states pt. normally walks on her own. She gotten up from the dining chair and lost her balance and fell on her left side. Staff used a (full body mechanical lift) and picked her up and placed her in the bed. Pt has dementia and is unable to tell us where it hurt other than holding the area. Pt was placed on the cot and secured. Pt left leg did look rotated outwards."

On 10/04/19 at 1:21pm, V12, R3's Power of Attorney/Family member stated she received a call from V3 the morning of 5/15/19 and was told that her mother had fallen, and they thought she'd fractured her hip.

V12 stated R3 was yelling out with pain to left hip,

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 10/16/2019

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 3	S9999		

as staff lowered her into bed. V12 stated she asked if they'd had a gait belt on her mother when she fell, and she was told by V13, Administrator at the time, that no gait belt was used but they were only used to "guide" the person. V12 stated staff often did not use a gait belt and she worried about her losing her balance and falling just like she did.

V12 stated she discussed her mother's falls with V6 and V5 who were present during the falls.

Hospital Records dated 5/15/19 documents R3 was admitted to the hospital with a left femur fracture (thigh bone) which required surgery.

On 10/04/19 at 12:42pm, V3, LPN stated R3 was in the dining room when she fell and was being assisted by a CNA. V3 stated she didn't remember if R3 had on a gait belt or not but did think her leg was rotated out. When asked why she would move R3 to her bed following the fall since she was showing some outward rotation, stated they didn't. This statement conflicts with the ambulance report.

On 10/04/19 at 1:15pm, V6 CNA stated she helped R3 get up from the table because she was just "supervision" and was standing on R3's right side when she started to fall toward the left. V6 stated she grabbed at her pants but was unable to steady her balance and she fell to the floor.

V6 stated she did not have a gait belt on R3 at the time of the transfer. V6 could not remember if they left R3 on the floor awaiting the ambulance or if they moved her to her bed in her room.

On 10/15/19 at 1:33pm, V2 Director of Nurses (DON) stated it is the policy of the facility to use a

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 10/16/2019

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 4	S9999		

gait belt on any pivot transfer or assisted ambulation.

The facility's policy/procedure entitled "Use of Gait Belt" undated documents the purpose as "It is the policy of this facility that staff will help control and balance (by using a gait belt) residents who require assistance with ambulation and transfer."

On 10/15/19, V11 MD responded to questions asked whether he would have expected the staff ambulating R3 to use a gait belt and responded "yes" adding that R3 ambulated was once up with her walker with one assist.

The facility's policy/procedure entitled "Fall Management" undated documents the purpose as "To evaluate risk factors and provide interventions to minimize risk, injury, and occurrences." Under "Procedure for responding to a fall," it documents "prior to moving the resident, evaluate for signs and symptoms of physical injury or trauma" and "evaluate actual or suspected causal factors to prevent reoccurrences".

(B)