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 12/17/2020

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 Investigation: #2049464/IL129185	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 300.3240a) 300.610a) 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. 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. 300.3240 An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) 300.610	S9999	**Attachment A** Statement of Licensure Violations	

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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.

These regulations were not met as evidenced by:

Based on observation, interview and record review the facility failed to provide supervision and progressive interventions to prevent falls for 3 of 3 residents (R1, R2, R3) reviewed for falls in the sample of 5. This failure resulted in R2's fall sustaining fractures to her ribs, hip and pelvis.

Findings include:

1. R2's Face Sheet titled "Transfer/Discharge Report" dated 12/16/2020 documents R2 was admitted to the facility 7/13/2020.

R2's Care Plan dated 7/15/2020, documents that R2 is at risk for falls. Interventions include: Encourage use of call light and Ensure call light is within reach. R2's Care plan further documents that R2's Care Plan was Revised on 12/15/2020 to include "Tennis balls placed on walker."

The Facility's Fall Log documents that R2 fell on 11/5/2020 and again on 12/1/2020.

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S9999	Continued From page 2 R2's Fall Investigation dated 11/5/2020 at 4:15 PM, documents that R2 was witnessed standing in the hallway, attempting the go back to her room and tripped on her walker. This event was witnessed by V4, Registered Nurse (RN). It further documents that R2 had no injuries, was able to get up while denying assistance. It further documents, "Root cause-Resident tripped over walker because resident was standing at ambulance door for a length of time. Intervention: Is to offer resident a chair to sit in if she insists on looking at ambulance door." R2's Care Plan, reviewed on 12/15/2020, does not reflect this intervention or any other interventions added after R2's fall on 11/5/2020. The Facility's Abuse Log documents that on 12/1/2020, R2 had a fall with injury. R2's Report Form- IDPH (Illinois Department of Public Health) Notification dated 12/1/2020 at 7:10 AM, documents, "(R2) had a non-fatal accident and that (R2) was sent to the ER (Emergency Room) for evaluation." R2's Verification of Incident Investigation/Administrative Summary dated 12/1/2020 documents, "Type of incident: Fall with injury." The investigation further documents, "Brief Description of Incident/Event: Resident sustained a witnessed fall while ambulating with their wheeled walker." It further documents, "Immediate Actions Taken: Head to toe assessment completed. Skin tear noted to left elbow. ROM (Range of Motion) assessed and WNL (Within Normal Limits) for resident. Resident noted to be barefoot, non-skid socks applied. Resident continued to ambulate with wheeled walker."	S9999		

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R2's Care Plan, reviewed on 12/16/20, does not reflect this intervention or any other interventions added after R2's fall on 12/1/2020.

The Initial and Final Report with Investigation and Conclusion documents, "On 12/2/2020, resident voiced complaints of increased pain to back and leg stating that she had fallen at Wal-Mart parking lot. MD (Medical Doctor) notified of increased pain. Order obtained to send resident to ER for evaluation and treatment. ER called to inform nurse on duty that resident had sustained fractures of left ribs #2, 3, and 7, as well as an acute inferior and superior pubic ramus (pelvic) fracture. Report from ER also reads there is hardware fixation of the left femoral neck with persistent fracture (not yet united). Admission history and physical shows that left hip fx (fracture) and pinning were addressed in June of 2020. MD and POA (Power of Attorney) agreed that hip will be treated non-operatively. Resident returned to facility on 12/2/2020 with incentive spirometry and orders for Motrin and Acetaminophen to be given per label instructions."

R2's X-ray report from the hospital, dated 12/2/2020, documents, "Impression: Nondisplaced lateral left 2nd, 3rd, and 7th ribs at the lateral aspect."
R2's CT (Computerized Tomography) report, dated 12/2/2020, documents, "Impression: 1. Minimally displaced fracture the left superior and inferior pubic ramus (pelvis)."

R2's Physician's Order Sheet (POS) documents that an order was obtained on 12/8/2020 for "Norco Tablet 5-325 MG (Narcotic Pain medication): Give 1 tablet by mouth every 6 hours

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S9999	Continued From page 4 as needed for moderate pain (4-6 on pain scale)." On 12/15/2020 at 1:00 PM, R2 was observed in her bed, up against the wall and one side rail raised on the opposite side. There was no fall mat present. R2's call light was tied to the side rail but was dangling down towards the floor. R2's wheeled walker with tennis balls on the bottom of it, was observed in the room, out of R2's reach. An attempt to interview R2 was initiated at this time. R2 stated, "My left side is dead. I can't walk anymore. I'm ready to go with my mom again. I had a good life. I fell at Wal-Mart." On 12/15/2020 at 2:10 PM, V6, Certified Nursing Assistant (CNA) came into R2's room to see if she would go to the bathroom. R2 declined. At this time, V6 stated, "She can still ambulate with our help. She uses her call light." V6 then left R2's room. R2's call light was still in the same position as it was before (dangling off the side rail, on the floor) at 1:00 PM. R2 grimaced and stated that her pain "comes and goes." When asked if she could use her call light to get help, R2 did not acknowledge the question but instead complimented the surveyor on her outfit. On 12/15/2020 at approximately 2:15 PM, V11, Licensed Practice Nurse (LPN), came into R2's room with pain medication for R2. R2 stated her pain was at an 8 after V11 explained the 1 to 10 pain scale. V11 left the room after administering R2's pain medication. R2's call light remained on the floor. On 12/15/2020 at approximately 3:00 PM, V8, Care Plan/ MDS Nurse, stated, "I have not done the MDS (Minimum Data Set) on her. I am still working on them. Her (R2's) Care Plan is a mess. I'm not going to lie to you."	S9999		

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S9999	Continued From page 5 On 12/16/2020 at 8:56 AM, V4, RN, stated, "I worked the day after (R2's) fall (12/2/2020). (R2) was complaining about pain in her left hip and leg and side. She had fallen and broken her left previously before coming to the nursing home, so she did have some pain in the left hip before. Did she say she fell at Wal-Mart? She did before. She'll tell you she's fine and doesn't want bothered. I think it was shift change (When R2 fell on 12/1/2020) and (V5, RN) was the nurse when she fell. (V5) stayed over to assess her. I read fall report. It said she got up by herself with walker. (R2) does not use her call light. (R2) would just get up on her own and did fine with walker." On 12/16/2020 at 11:45 AM, V3, Assistant Director of Nursing (ADON), stated, "After (R2's) fall on 11/5/2020, we put a chair by the door. She likes to look out (ambulance door) in case she wanted to sit down. We added the tennis balls to her wheelchair before today, but I have no way of proving that. We added it to the Care plan yesterday as we (V2, Director of Nursing, DON, and V3) were going over falls." On 12/16/2020 at 4:02 PM, V12, CNA, stated, "I worked day shift the day (R2) fell but I didn't witness it. I was down the hall with another resident. I didn't notice anything different. (R2) was up and walking like she normally does. I was told she (R2) has fractures in her hip and ribs. I do not know of any other changes other than she (R2) has been staying in bed more. (R2) can get up with two assist and walker now. I am not sure how long the tennis balls have been on her walker. There is not usually a chair by the ambulance door because we don't want anything blocking the doors. (R2) doesn't use call light very often."	S9999		

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S9999	Continued From page 6 On 12/17/2020 at 8:05 AM, V5, RN, stated, "My relief was late the morning of (R2's) fall. There was another fall before hers (R1). I was standing at the nurses' station charting on (R1's) fall. (R2) was in her room standing up from her bed. She was talking to her roommate and her lost balance. She's not completely with it and doesn't always use walker correctly. (R2) is able to use her call light, but I don't think she ever presses it. (R2) likes to do things herself. After (R2's) fall, I was taking her vital signs and treating the skin tear to her elbow, she was fighting me, wanting to stand up. She then walked from roommates' side of the room and sat down and wanted coffee and breakfast. I was very, very surprised to find out she had all those fractures. There are a lot of falls. I'm being completely honest with you. Supervision/staffing is most definitely an issue as well as the acuity of the residents." On 12/17/2020 at 11:58 AM, V14, R2's Medical Doctor (MD) stated, "The facility called me. At first it didn't seem too serious until she developed pain. I then gave the order to send (R2) to the ER for an x-ray and that's what they found the fractures. The ER did not admit her. The goal is to keep (R2) comfortable. I was not there, so I did not investigate how she fell. I do know that before she was able to freely walk around. I don't know if her condition deteriorated. I think the NH (nursing home) is stressed due to the virus, so that may affect the level of care." 2. The facility's Fall Log documents R3 fell 9/21/2020, 10/3/2020, 10/7/2020, and 10/26/2020. The Fall Log documents that 2 falls of R3's were unobserved. R3's Care Plan dated 10/2/2020, documents, "At	S9999		

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risk for falls and injuries related to medications. She will refuse to wear slipper socks or any-thing on feet, prefers to go barefoot, Dementia, she wanders quickly around the halls, has seizure disorder, weakness, HX (history) of falls." R3's Care Plan had no progressive interventions related to each of R3's falls listed on The Facility's Fall Log. R3's Care Plan documents the last intervention for falls was added on 9/21/2020 and was for physical therapy to evaluate for strengthening.

R3's Care Plan documents on 6/1/2020 an intervention was added to R3's Care Plan, "Room move due to roommate will ask (R3) to get up and do things for her."

R3's MDS dated 10/7/2020, documents that R3 requires extensive assist of one staff to walk in the corridor.

On 12/15/2020 at 12:45 PM, R3 was observed wandering the halls wearing a gown and a pair of socks, unsupervised.

On 12/15/2020 at 1:55 PM, R3 was observed walking by herself in hallway, unsupervised.

On 12/15/2020 at 2:15 PM, R3 was observed pushing her roommate in her wheelchair down the hall, without supervision or redirection of staff.

On 12/15/2020, R3 asked this surveyor, "Will you hold my hand and walk with me?" This surveyor redirected the resident by asking R3 to show the surveyor where her room was. R3 took this surveyor to her room and R3 sat in her recliner. R3 was able to show the bottom of R3's socks which were the non-skid type.

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S9999	Continued From page 8 On 12/16/2020 at 11:45 AM, V3, ADON, stated, "(R3) ambulates independently without a walker. What are you supposed to do with someone who is independent? (R3's) MDS is not true." V3 continued to state, "(R3) pushes her roommate. The roommate is the brains, (R3) is the feet." V3 continued to state, "There were interventions in place, they just weren't on the Care Plan. (V8) MDS/Care Plan Nurse, is still new." On 12/17/2020 at 8:00 AM, V5, RN, stated, "(R3) is confused and wanders. (R3) will walk around until she falls. We attempt to re-direct her, but it doesn't always work. It's not safe, but she doesn't understand." The Facility's Fall Management policy and procedure, dated 11/7/19, documents, "Fall Prevention Procedure: 1. Evaluate risk factors for sustaining falls upon admission, with comprehensive assessments and while conducting interdisciplinary care plan reviews 2. Initiate a fall prevention care plan, when appropriate, with strategies to minimize risk and/or potential for injury 3. Review, revise and evaluate care plan effectiveness at minimizing falls and injury during care plan reviews as needed. 3. R1's Electronic Health Record (EHR) documents that R1 was admitted to facility on 11/12/2020 with a diagnosis to include, history of falling, dysphagia, open wound, left hip, essential (primary) hypertension, hypothyroidism. On 12/15/2020 at 12:30 PM, R1 was observed lying in a scoop mattress, bed low to floor and a mat was located on left side of bed. R1 stated that she wanted a hot cup of coffee. R1 was alert to self. R1 observed with a large fading bruise to	S9999		

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S9999	Continued From page 9 right forehead area. On 12/15/2020 at 1:30 PM, V3, ADON, stated (R1) falls all the time. V3 stated, (R1) falls are all documented on SBAR (Situation background assessment recommendation) and not in R1's progress notes. On 12/16/2020 at 10:12 AM, V7, Pending Certified Nursing Assistant (PCNA), stated, "(R1) has had a lot of falls, I have been told about them." V7 stated, (R1) is very unstable and that there is 2 staff to assist with transfers. V7 stated, (R1) doesn't completely understand (directions). On 12/16/2020 at 10:05 AM, V4, RN, stated (R1) is full care. V4 stated when giving (R2) directions, "I don't think it's 'clicking'." V4 stated, "No, (R1) didn't have enough supervision the night she fell." V4 stated, "When (R1) came to facility she was a wanderer, (R1) was all over the place." R1's SBAR dated 11/19/2020 at 08:45 AM, documents unwitnessed fall in hallway, unable to communicate what happened. (R1) sustained no physical injuries. R12's SBAR documents that (R1) was found on floor near bathroom, (R1) wandering, resident in and out of isolation bins and anything in the hall. (R1) leaned forward resulting in (R1) sliding out of WC (wheelchair) onto floor onto buttocks. No injuries noted. ROM (range of motion) WNL (within normal limits). Able to move all extremities. R1's Care Plan dated 11/12/020 had no new interventions for the fall that occurred on 11/19/2020. R1's Care Plan dated 11/12/2020 documents, (R1) is at risk for falls and injuries r/t (related to)	S9999		

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Medications: Pychotropic Meds/ Diuretic Meds/ Cardiovascular Meds/ Pain Meds/ IV medications.
Medical Factors: Is on IV ABT (IV antibiotics) due to wound infection of the left hip.
Interventions: Encourage use of call light (initated 11/12). (non slip device) on top of wheelchair cushion. She does remove (non slip device) quite often on her own. Please encourage to leave in. (initated 11/29). Toilet after all meals Date Initiated: 11/21/2020.
Foot boards for wc (wheel chair) provided Date Initiated: 12/09/2020. Keep call light within reach.Date Initiated: 11/12/2020. Keep environment clutter free Date Initiated: 11/12/2020.
Keep personal belongings within reach Date Initiated: 11/12/202. Provide adequate lighting Date Initiated: 11/12/2020. Tab alarm applied to resident Date Initiated: 11/13/2020

R1's SBAR dated 11/21/2020 at 1:50 PM documents Unwitnessed fall from wheelchair. Function Level Prior to Incident: Needs Assistance. Unable to communicate what occured. Oriented to Person. Briefly describe the nature of occurrence: "Writer called to room by CNA when arriving resident sitting in doorway of room on the floor in front of her wheelchair. (R1) on her buttocks legs extended out, no complaints of pain. mae (moves all extremities). no physical trauma noted. when asking resident what she was doing resident states, 'I don't know' let resident know she needed to call for help her response 'what for' (R1) assisted to bed at this time."

R1's intervention for 11/21/2020 Fall: Toilet after meals.

R1's SBAR dated 11/29/2020 at midnight

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documents, (R1) was reaching for an item on a bedside table when she scooted too close to the edge and slid to the floor. Denies pain. (R1) has a red mark down the left flank area from a part on the wheelchair (foot pedal). Foot pedals were on at time of fall. Alarm not sounding due to resident having on a housecoat and the coat went up her back not allowing for the alarm tab to pull. A dycem (non slip) sheet was also placed under her cushion. Alarm failure or device removal.

R1's interventions for 11/29/2020 fall documents, Fall Intervention: Dycem on top of wheelchair cushion. (R1) does remove Dycem quite often on her own. Please encourage to leave on.

R1's SBAR dated 12/01/2020 at 6:20 AM documents, 'Writer called to room, (R1) was sitting upright in front of bed on floor mat, bed was completely lowered to the floor. Alarm failure or device removal. Call light not activated. Assessment: Unable to communicate what occurred.

R1's Care Plan has no new interventions for the fall that occurred on 12/01/2020.

R1's SBAR dated 12/08/2020 at 8:30 PM documents, Un-witnessed fall in R1's room. (R1) appears to have sat on side of bed and slide off mattress onto floor mat no injuries noted no c/o (complain of) restless anxious alarm in place resident place in wheelchair and taken to nurses station alarm in place.

R1's SBAR dated 12/8/2020 at 8:55 PM documents, Un-witnessed fall in hallway. (R1) unable to communicate what happened. Briefly describe: Heard alarm and loud noise immediately came out of another room and saw

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(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 12 (R1) laying on right side with lower part of wheelchair underneath her alert to name. (R1) able to make needs known no laceration or skin tear noted (R1) c/o discomfort to hip and lower legs and to lower back no SOB (shortness of breath) even neuro check WNL (within normal limits). Transfer to Emergency Department for evaluation. R1's Care Plan has no new fall interventions for the falls that occurred on 12/8/2020. R1's progress note dated 12/8/2020 documents, (R1) returned to facility via ambulance alert to name able to make needs known neuro checks WNL hematoma noted to right side of head ice applied as ordered no c/o alarm in place bed in low position no fx (fracture) noted at hospital POA (power of attorney) aware was at hospital with mother. On 12/16/2020 at 12:11PM, V9 (R1's POA) stated, A couple of times I don't think that the facility called me when (R1) fell a couple of times, the last 3 weeks for sure. V9 stated, Yes, six falls is alot. On 12/16/2020 at 3:30 PM, V10, R1's Physician, stated effective (care plan) interventions and adequate supervision would have prevented R1 from falling. (A)	S9999		