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
	IL6009427	A. BUILDING: ______ B. WING ______	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOULON REHAB & HEALTH CARE CENTER	HIGHWAY 17 EAST TOULON, IL 61483

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S 000	Initial Comments Facility Reported Incident Investigation to incident of 12/5/21 IL141245	S 000		
S9999	Final Observations Facility Reported Incident Investigation to incident of 12/5/21 IL141245 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 care and personal care shall be provided to each resident to meet the total nursing and personal	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

care needs of the resident.

Section 300.1210 General Requirements for Nursing and Personal Care
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 regulations were not met as evidenced by:

Based on interview and record review, the facility failed to identify and treat a residents pain for one of three residents (R4) reviewed for pain in the sample of four. This failure resulted in R4 suffering a fall with a laceration to the forehead and requiring emergency medical treatment.

Findings include:

The facility's Pain Prevention and Treatment policy, dated 12/7/17, documents, "It is the facility policy to assess for, reduce the incidence of and the severity of pain in effort to minimize further health problems, maximize ADL (Activities of Daily Living) functioning and enhance quality of life. Responsibility: All Nursing Personnel." This policy also documents, "Assessment of pain will be completed with changes in the resident's condition, self reporting of pain or evidence of behavioral cues indicative of the presence of pain and documented in the nurses notes or on the Pain Management Flow Sheet. This will include,

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S9999	Continued From page 2 but is not limited to, date, rating, treatment intervention and resident response." R4's recent Minimum Data Set assessment, dated 10/12/21, documents R4's cognition is severely impaired. R4's current Care Plan, dated 10/27/21, documents "(R4) has pain risk, alteration in comfort/pain related to neuropathy and unstageable area to coccyx. Intervention: Monitor for indicators of pain. Assess location and duration of pain and any contributing factors." R4's Nursing Progress Notes, dated 12/5/21 and signed by V7 (Licensed Practical Nurse), documents, "1:00 AM, (R4) alert with usual confusion, combative and resistive with ADLs. Turn/Position frequently, incontinent of bowel and bladder, peri-care provided and treatment done per orders. 1:45 AM, See AIMs (Assess. Intercommunicate. Manage.) form." R4's AIM for Wellness form, dated 12/5/21 at 1:45 AM, documents R4 was found face down on the floor with behaviors of being resistive and combative and expressing non-verbal signs of pain by crying and tearfulness. This form also documents R4 suffered a laceration measuring 3 centimeters to her forehead and was transported to the local Emergency Room for treatment. R4's Investigation Report for Falls, dated 12/5/21 and signed by V2 (Director of Nursing), documents, "Resident (R4) is non-verbal, found lying face down next to her bed. Areas of concern identified for further analysis: Pain control." R4's Quality Care Reporting form, dated 12/6/21	S9999		

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S9999	Continued From page 3 and signed by V2 and V1 (Administrator), documents, "Summary of event and action taken: Noted (R4) on floor, root cause due to increased pain from wound treatment completed, and progressive Dementia disease process." On 12/13/21 at 3:52 PM, V7 (Licensed Practical Nurse) confirmed she took care of R4 on 12/5/21 at the time of her fall. V7 stated she had completed R4's wound treatment just prior to R4 falling. V7 stated, "During her wound treatment, before she fell, (R4) was hitting, that's what she does. (R4) does have pain but she's non-verbal. She can be combative or resistive and tearful when she has pain. I don't know if she was tearful that night. If it were me, yeah I'd be in pain. (R4's) wound and treatment probably hurts. I don't have her chart so I don't know if she was given pain medication." On 12/14/21 at 1:45 PM, V9 (Certified Nursing Assistant) confirmed she assisted V7 with R4's wound treatment and cares on 12/5/21. V9 stated, "During (R4's) dressing change that night she was combative with care. When (R4) is in pain, she will groan and cry out and be resistive and combative." R4's Medication Administration Record (MAR), dated 12/1/21-12/31/21, documents R4 was given scheduled Oxycontin (narcotic pain medication) 10 milligrams extended release at 5:00 AM on 12/4/21. This same MAR does not document any other pain medication was given to R4 prior to cares or the wound treatment on 12/5/21 at 1:00 AM (20 hours after pain medication). On 12/13/21 at 11:30 AM, V2 (Director of Nursing) stated, "(R4) has a significantly large pressure ulcer on her coccyx and it causes her a	S9999		

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S9999	Continued From page 4 lot of pain. The root cause of her fall is pain and the pain is from her wound treatment being done that night. Her pain medication is only given in the morning. Her wound treatment is scheduled for third shift." V2 confirmed R4 does have orders for PRN (As Needed) Tylenol but was not given any on 12/4/21 or 12/5/21. On 12/13/21 at 1:00 PM, V1 (Administrator) stated, "The root cause of (R4's) fall ultimately was determined to be pain due to the nurse (V7) telling us that (R4) was having pain during her wound treatment which occurred prior to the fall." (B)	S9999		