PRINTED: 03/15/2022

Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: \_ COMPLETED IL6009369 B. WING 01/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH HOUSTON **TAYLORVILLE CARE CENTER** TAYLORVILLE, IL 62568 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** TAG COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 **Initial Comments** S 000 Complaint Investigations 2240170/IL142170 2240203/IL142205 2240437/IL142555 2240565/IL142716 S9999 Final Observations S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) Section 300.610 Resident Care Policies The facility shall have written policies and a) 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

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b)

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

well-being of the resident, in accordance with

The facility shall provide the necessary

care and services to attain or maintain the highest practicable physical, mental, and psychological

Nursing and Personal Care

TITLE

Attachment A

Statement of Licensure Violations

(X8) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY					
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		is Stage II-III decubing with pale yellow bas note on this docume PM, documents R4 sore that will likely himtervention, no sign 8 cm (centimeter).  R4's Resident Inform 12/3/2021, document on 12/3/2021.  R4's Minimum Data a documents R4 is an person assistance for and Toilet use.  R4's initial assessme Facility, dated 12/3/20 pressure stage 2: Palexposed dermis, Presideasurements 6.5cm 2.7cm (width) with Detail Tunneling, Granulation slough to the wound be dead tissue), no evide amount Serous Exudation wound; Edges Attachewound bed or as a slotissue; Blanching (whin Normal in color, No in	Set (MDS), dated 12/11/21, extensive assist with 2 plus r Bed mobility, Transfers, ant on admission to the 021, documents sacrum rtial thickness skin loss with sent on Admission, Wound of (area) 4.0cm (length), epth, no Undermining and with the presence of eschar lence of infection, light ate with no odor noted. Peri ed: Edge appears flush with oping edge, Surrounding itening of external tissue), duration, swelling or round temperature: Orders:									
	F ()	R4's Care Plan, dated R4) is at risk for press preakdown related to d	12/13/2021 document's sure ulcers or skin					ĺ				

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R4's Hospital record dated 12/30/2021

documents, Surgical Pathology Report 12/31/21, Final Pathologic Diagnosis, soft tissue, sacral

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