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 _____	09/28/2023

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

(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 Annual Licensure Survey	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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 as evidenced by: Based on observation, interview, and record review, the facility failed to investigate unwitnessed falls and adequately supervise a resident (R65) with a known history of wandering to prevent them from entering another resident's room (R60) startling her and causing a fall for two of two residents (R60, R65) reviewed for falls in the sample of 34. This failure resulted in R60 obtaining a hemorrhagic pelvic fracture. Findings include: The facilities ELOPEMENT PREVENTION POLICY, dated 10/06, documents "5. The Interdisciplinary Team will initiate a plan of care for any resident determined high risk for elopement. Facility specific measures as well as resident specific measures will be included in each high-risk resident's plan of care to minimize risk factors." R65's Care plan, dated 4/24/23, documents, "(R65) has behaviors that others may find disruptive/socially inappropriate." This same care plan also documents "Behaviors noted of verbal	S9999		

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S9999	Continued From page 2	S9999		

aggression, seeking female peers' attention, refuses medication, is easily agitated during redirection, is socially inappropriate. (R65) has a diagnosis of late onset Alzheimer's, dementia with behavioral disturbance, bipolar d/o (disorder), and anxiety. (R65) ambulates without device with supervision, directional, and verbal cues. (R65) does wander."

R65's Psychosocial History, dated 4/14/23, documents that R65 is an elopement risk.

R65's Elopement Evaluation, dated 4/14/23 and 4/25/23, documents that R65 has an inability to identify safety needs, has altered perception of awareness leading to seeking exit/escape, his level of agitation has required supervision, and he wanders in the vicinity of exit doors.

R60's PT (Physical Therapy) Daily Treatment Note, dated 5/4/23, documents "(R60) ambulated within the facility on even and uneven surfaces such as carpet with FWW (front wheeled walker) at a supervision level. Completed all transfers with SBA (stand by assistance) using FWW." The PT Daily Treatment Note, dated 5/8/23, documents "(R60) has continued to progress towards all established goals. (R60) has demonstrated improved endurance and ability to complete all daily tasks with less assist."

R60's A.I.M. (Assesses, Intercommunicate, Manage) for WELLNESS, dated 5/20/23, documents, R60 was "Noted on floor lying on her right side. Pain pill given c/o (complaints of) pain everywhere. Unable to ambulate. Neuro (neurological) checks WNL (within normal limits). Had 1 emesis during lunch. Sending her to ER (Emergency room) to eval (evaluate) and Tx (treat). She was startled by another resident

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S9999	Continued From page 3 (R65) in her bathtub in her bathroom." R60's Nurses Notes, dated 5/20/23 at 7:30 PM, documents "Received update from (local hospital), patient has a fracture of pelvis in multiple places, it is hemorrhaging. Transferring to (a critical care hospital) ICU (Intensive Care Unit). R60's Discharge Summary, dated 5/25/23, documents "(R60) was initially evaluated in the trauma bay by the trauma team after a ground level fall at SNF (Skilled Nurse Facility). She was found to have: pubic rami fracture, bilateral sacral insufficiency fractures. Fracture dislocation of left glenohumeral joint. Ortho (Orthopedics) took her the OR (Operating Room). Was discharged back to SNF in stable condition on 5/25." On 9/26/23 at 10:00 AM, R60 stated "After breakfast (on 5/20/23), I went back to my room and took a 2-hour nap. I heard some knocking, but I thought it was construction or somebody fixing something. I got up to use the bathroom and when I opened the door, a guy was laying in my bathtub. It startled me and I turned to head out the door and that's when I went down. I landed on my right side. I was taken to the hospital within 30 minutes. I know who he is. His name is (R65) and he has dementia. He's known around here for going into peoples' rooms. He must have been in the bathroom when I came back from breakfast. I was doing great with therapy. I was riding the bike for 20 minutes and walking fast. Then I had to start all over (with rehabilitation) after I fell." The facility's Final Report to the State Agency, dated 5/20/23, documents, "Female resident noted on ground in room. Resident sent to ER for	S9999		

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S9999	Continued From page 4 eval and treat. 5 day to follow. Resident was admitted to hospital due to fractured pelvis. Root cause determined the be loss of balance. Intervention resident educated to use walker during ambulation. Resident will return to facility with therapy services. Care plan and POA (Power of Attorney) updated." The report lacked documentation R65 was on elopement precautions; was a known wanderer and found in the bathroom which resulted in R60's fall. On 9/26/23 at 12:30 PM, V14 (Licensed Practical Nurse) stated "(R65) was laying in the bathtub. It looked like he sat on the edge of the tub and fell back with a leg hanging over the side and his hands behind his head. He looked really comfortable. He didn't have any injuries. I did neuro checks and movement assessments He is very much so a wanderer. He required extreme supervision with activity's but does walk independently. If we have wanderers, we should be doing every 15-minute checks and try to keep them close to us." On 9/26/23 at 1:25 PM, V10 (LPN) stated "Yes, I remember it (5/20 incident). That's not something you find every day. When I got into the room. (R60) was lying on the floor with her walker beside her. Other people were in there checking out R65. I was checking out (R60). I had to send her to the hospital because she was unable to ambulate. No one from higher up asked me any questions after the fact." On 9/28/23 at 10:00 AM, V11 (Certified Nursing Assistant) "After breakfast, we were looking for (R65). I heard (R60) scream and found R65 in R60's bathtub. I think he fell backwards. He said he wanted to take a bath. We yelled up the hall for help. I was helping with (R65) and V12 (CNA)	S9999		

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S9999	Continued From page 5 was assisting (R60). (R60) went that day to the hospital for complaints of hip pain." V11 denied being interviewed by the Director of Nursing (V2) or the Administrator (V1) regarding R60's fall. On 9/28/23 at 10:15 AM, V12 (CNA) stated "I told V11 "Let's go check on (R60)." When we got there (R60's room), R65 was in the bathtub and R60 was on the floor. I don't know how long (R65) was in there. R60 told me she heard knocking but thought it was construction. (R60) complained of pain. After the nurse checked her out, we sat her up and put her in a chair." On 9/26/23 at 11:45 AM, V1 (Administrator) stated an investigation and interviews were not conducted related to (R60's) falls which were unwitnessed. V1 confirmed R60's root cause for the fall on 5/20/23 was not related to just the loss of balance but also from R65's wandering and an investigation was not conducted and should have been. (A)	S9999		