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 06/17/2024

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 Complaint Investigation 2424422/IL174000	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1210d)5 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	S9999		

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 06/17/2024

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
S9999	Continued From page 1	S9999		

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.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to develop and implement pressure relieving interventions once a resident was assessed as being at high risk of developing

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 06/17/2024

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
S9999	Continued From page 2	S9999		

pressure ulcers, failed to assess a pressure ulcer's stage and size once identified, failed to perform daily skin checks as ordered by the physician, failed to perform physician ordered wound treatment, and failed to perform pressure ulcer risk assessments every week for four weeks after admission and quarterly thereafter, as instructed by the facility's policy, for one of three residents (R1) reviewed for pressure ulcers in the sample of five. These failures resulted in R1 developing a facility acquired stage three pressure ulcer to the right medial ankle.

Findings include:

The Pressure Sore Prevention Guidelines policy dated 3/16/23, documents "Policy: It is the facility's policy to provide adequate interventions for the prevention of pressure ulcers for residents who are identified as HIGH or MODERATE risk for skin breakdown as determined by the Braden Scale. Responsibility: all nursing staff and the dietary manager. Interventions/Comments for High-Risk residents. Special Mattress/Specify type of mattress on the Care Plan. Daily Skin Checks/follow protocol for coding skin conditions. Interventions/Comments for High or Moderate Risk residents: Turn and reposition every two hours. Turning and positioning may be more often than every two hours for high risk, if indicated. Care Plan Entry/Skin risk and appropriate interventions are to be placed on the Care Plan. If despite interventions a pressure ulcer develops, the care plan must reflect updated interventions for healing of ulcers and additional interventions for further prevention of Pressure Ulcers. Interventions/Comments as needed for High or Moderate Risk residents. Positioning Devices/Devices while in chair or in bed as needed to maintain turning. Specify on Care Plan.

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 06/17/2024

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
S9999	Continued From page 3	S9999		

"Any resident scoring a High or Moderate risk for skin breakdown will have scheduled skin checks on the Treatment Record. Skin checks will be completed and documented by the nurse."

The facility's Preventative Skin Care policy dated 01/2018 documents, "Policy: It is the facility's policy to provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident's skin condition to keep them clean, well-groomed, and free from pressure ulcers. Procedures: All residents will be assessed using the Braden Pressure Ulcer Scale at the time of admission and weekly times four then will be re-assessed at least quarterly and/or as needed. Any resident identified as being at high risk for potential skin breakdown shall be turned and repositioned at a minimum of every two hours. Pillows and/or bath blankets may be used between two skin surfaces to slightly elevate bony prominences/pressure areas off the mattress. Pressure relieving devices may be used to protect heels and elbows. Ensure proper fit of wheelchairs, splints, braces, prosthesis, and shoes."

R1's Admission Record documents R1 is a 45-year-old admitted to the facility on 6-22-23 with the diagnoses of Paraplegia, Arnold-Chiari Syndrome with Spina Bifida, Abnormal Posture, and Wheelchair Dependence.

R1's Admission Braden Scale for Predicting Pressure Ulcer Risk Assessment dated 6-22-23 documents R1's risk score "16" indicating R1 was at a high risk of development of pressure ulcers. This same Braden Scale Risk Assessment documents R1 did not have any pressure ulcers or wounds upon admission to the facility.

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 06/17/2024

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
S9999	Continued From page 4	S9999		

R1's Medical Record dated 6-22-23 through 6-15-24 does not include any further Braden Scale Pressure Ulcer Risk Assessments.

R1's Baseline Admission Care Plan dated 6-22-23 documents R1 was dependent upon two staff for bed mobility, toileting, and transfers. This same Baseline Admission Care Plan does not include any identified pressure ulcer risks or pressure relieving interventions.

R1's MDS (Minimum Data Set) Assessments dated 7-3-23 (admission), 12-28-23 (quarterly), and 3-25-24 (quarterly) document R1 is cognitively intact, requires assistance of staff for turning left to right in bed, is at risk for development of pressure ulcers, and does not have any pressure ulcers. R1's MDS dated 3-25-24 documents R1 is not on a turning and repositioning program.

R1's Physician's Order dated 9-10-23 documents, "Hydrofera Blue (antibacterial foam dressing) ready foam external pad apply to lower right ankle every Sunday."

R1's Medical Record does not include documentation of an assessment of R1's pressure ulcer to the right ankle once identified on 9-10-23.

R1's Progress Note dated 9-27-23 documents, "(R1's Family Member/V7) called and wanted to make sure staff knew that (R1) needed to be repositioned around 12:30 in the morning and every two hours. She stated she spoke to (R1), and he stated he hadn't been repositioned since earlier in shift."

R1's Wound Care Visit Summary Initial Encounter

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 06/17/2024

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
S9999	Continued From page 5	S9999		

dated 1-16-24 documents, "Wound of right ankle initial encounter. Cleanse with soap and water. Apply lotion to peri-wound. Apply hydro (water-filled) dressing blue ready transfer to wound bed. Wear tubigrip (elastic bandage). Change dressings every other day and as needed if dressings get wet or soiled. Skin checks must be done every shift to ensure no bunching of (elastic bandages)."

R1's Wound Care Visit Summary dated 6-6-24 documents, "Today's Visit: Pressure injury of right ankle, stage three. Wound Care Dressing: Right Medial Ankle. 1. Wash wound with soap and water. 2. Apply Prisma (collagen dressing formulated with oxidized regenerated cellulose and silver) to open part of the ulcer. 3. Cover with bordered foam. 4. Compression stockings during the day and take off at night. 5. Change dressing three times weekly and as needed if dressings get wet or soiled."

R1's Physician's Order dated 6-12-24 and signed by V4 (R1's Primary Physician) documents, "Cleanse right medial ankle with soap and water, apply (collagen dressing formulated with oxidized regenerated cellulose and silver) to wound bed, cover with border foam every day shift (on) Mondays, Wednesdays, and Fridays for wound care."

R1's Treatment Administration Records (TARs) dated 1-16-24 through 6-15-24 do not include documentation of evidence of skin checks being performed every shift as ordered on the Wound Care Visit Summary dated 1-16-24. These same TARs document R1 only received skin checks weekly during this timeframe.

On 6-15-24 at 9:15 AM R1 was sitting in

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 06/17/2024

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
S9999	Continued From page 6	S9999		

wheelchair in the dining room. R1 had only a sock covering his left foot and the left foot was placed on the left wheelchair foot pedal. R1 had a cotton cushioned boot to the right foot. R1 stated, "The sore on my ankle (right ankle) was caused from rubbing on either my wheelchair or my bed. I am not sure because I have no feeling in my feet."

On 6-15-24 at 10:40 AM R1 was lying in bed and V7 (R1's Family Member) was visiting (R1) at the bedside. V9 (LPN/Licensed Practical Nurse) removed a wound dressing to R1's right medial ankle. R1's right medial ankle wound was approximately 2 cm (centimeters) long by 1 cm wide by 0.2 cm deep, pink in color, with a small amount of clear drainage. V9 cleansed the right medial ankle wound with wound cleanser, applied collagen dressing to the wound and covered with a four-by-four bordered gauze. V9 stated, "(R1) was supposed to get a (collagen dressing formulated with oxidized regenerated cellulose and silver) treatment to the right medial wound. The wound clinic ordered (collagen dressing formulated with oxidized regenerated cellulose and silver) on Wednesday (6-12-24) and I ordered it from pharmacy. I have not worked the last two days, so I do not know if anyone has followed up on trying to get the (collagen dressing formulated with oxidized regenerated cellulose and silver) in. I just used the collagen dressing for now."

On 6-15-24 at 10:50 AM V7 (R1's Family Member) stated, "(R1) got the wound to his right ankle because when (R1) got here the staff were not putting on boots (pressure relieving boots) to (R1's) feet and (R1's) feet were not lifted off the bed. (R1) cannot feel his feet and cannot lift them off the bed. Somebody should have let me

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 06/17/2024

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
S9999	Continued From page 7	S9999		

know or the wound clinic know that (R1) needed Prisma so we could have gotten it for him. I would have gone to the wound clinic myself and picked up the (collagen dressing formulated with oxidized regenerated cellulose and silver) had I known the facility did not have it."

On 6-15-24 at 11:50 AM V9 stated the nurses have only been doing R1's skin checks weekly.

On 6-15-24 at 11:30 AM V1 (Administrator-In-Training) stated, "We (the facility) do not have a Care Plan Coordinator or MDS Coordinator currently. (R1's) medical record does not include any Braden Scale Pressure Ulcer Risk assessments since (R1's) admission to the facility." V1 also verified R1 did not have a care plan developed with pressure relieving interventions once R1 was assessed as being at high risk for pressure ulcer development upon admission to the facility.

On 6-15-24 at 3:20 PM V2 (Director of Nursing) "I was not aware of (R1) having an order from the wound clinic to check (R1's) skin every shift. The only documentation I can find is that (R1's) pressure ulcer to the right ankle started on 9-16-23. I cannot find an assessment in (R1's) medical record that indicates what the pressure ulcer looked like, the stage, or what it measured when it was found. That is the first date that I see a physician's order for a treatment to the wound on (R1's) right ankle. (R1's) skin checks have only been done weekly. I did not know there was an order from the wound clinic to do the wound checks daily on every shift."

(B)

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 06/17/2024

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
S9999	Continued From page 8 2 of 2 300.610a) 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. 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:	S9999		

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 06/17/2024

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
S9999	Continued From page 9	S9999		

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 ensure a resident's bed was kept in the lowest position, failed to keep resident personal items and call light within reach, failed to ensure a resident was secure while being transported in the facility van, failed to investigate a fall, failed to implement and revise fall interventions, and failed to update the fall care plan after a fall for one of three residents (R1) reviewed for falls with injuries in the sample of five. These failures resulted in R1 falling out of bed while reaching for his cell phone while his bed was in a high position, sustaining a left femur fracture, and R1 falling forward out of his wheelchair while being transported in the facility van causing R1 to experience neck and shoulder pain, fear, and emergency department treatment for pain.

Findings include:

The facility's Fall Prevention dated 11/10/2018 documents, "Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility. Responsibility: All staff. All falls will be discussed in the morning quality assurance meeting and any new interventions will be written on the care plan. 5. Immediately after any resident fall the unit nurse will assess the resident

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 06/17/2024

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
S9999	Continued From page 10	S9999		

and provide any care or treatment needed for the resident. 6.The unit nurse will place documentation of the circumstances of a fall in the nurse's notes or in a A.I.M. (Acute Illness Management) for Wellness form along with any new fall interventions deemed to be appropriate at the time."

1. On 6/15/24 at 9:15 AM R1 was sitting in wheelchair in the dining room. R1 stated, "When I rolled out of bed (on 7/19/23) I was reaching for my cell phone and could not reach it. My remote to my bed was hanging down and I could not reach it. The staff did not leave it on my table beside me. I fell to the floor and broke my leg. The staff had left my bed high, so I fell from really far up. I needed help forever. I called my mom to come and help me. (V7/R1's Family Member) showed up to help me before the staff even came in to help."

On 6/15/24 at 10:20 AM R1 was lying in bed flat, with the bed in the highest position. (V7) was at (R1's) bedside. No staff were supervising R1 in the room during this time. V7 stated, "The staff always leave (R1's) bed in the highest position when I visit. I do not know how many times I have told staff that (R1's) bed needs to be low. When (R1) rolled out of bed and fractured his femur (on 7/19/23) he called me while he was on the floor and asked me for help because no staff was responding to him. I got to the facility and found (R1) laying on the ground beside his bed. (R1) had bruising to his hip and his bed was in the high position when (R1) rolled out. (R1) said he was reaching for his cell phone because the staff did not leave his phone within his reach. (R1's) knee was swelling more every day after the fall on 7/19/23 so I insisted the facility get (R1) an x-ray and that is when they found (R1) had a

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 06/17/2024

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
S9999	Continued From page 11	S9999		

fractured his femur. (R1) would not have fractured his femur if his bed was low and his cell phone was within reach."

R1's Admission Record documents R1 is a 45-year-old admitted to the facility on 6/22/23 with the diagnoses of Paraplegia, Arnold-Chiari Syndrome with Spina Bifida, Abnormal Posture, and Wheelchair Dependence.

R1's MDS (Minimum Data Set) Assessment dated 3/25/24 documents R1 is cognitively intact.

R1's A.I.M. for Wellness dated 7/19/23 and signed by V16 (RN/Registered Nurse) documents R1 had a change of plane (fall) while trying to reach for his cell phone and slight discoloration was noted to the right hip.

R1's Investigation Report for Falls dated 7/19/23 and signed by V16 documents R1 stated he was tired of waiting and wanted out of bed, was incontinent when found on the floor, and R1's call light was not within reach.

R1's Progress Notes dated 7/27/23 document R1 was at another medical facility receiving care and R1's left knee was swollen, so an x-ray was obtained.

R1's X-Ray Left Knee Report dated 7/27/23 documents, "Impression: Distal Lateral Femur concerns for acute mildly displaced fracture."

R1's Hospital After Visit Summary dated 7/28/23 documents, "Reason for visit: Knee injury. Diagnosis; Aftercare for healing traumatic fracture of left femur. Instructions: Leave knee brace intact until evaluated by orthopedics (8/1/23).

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 06/17/2024

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
S9999	Continued From page 12	S9999		

R1's Orthopedic Progress Notes dated 8/1/23 and signed by V18 (Orthopedic Surgeon) document, "(R1) fell while trying to lean over for cell phone and injured his femur. He has a lateral femoral condyle fracture. Non-operative care and follow-up in six weeks."

2. The facility's Van Usage Policy and Procedure (undated) documents, "The purpose of this policy is to establish procedures by which employees formally acknowledge and accept responsibilities of operating a facility owned van on behalf of (the facility). Further, it establishes requirements for enforcement of operating procedures and safe driving practices. When employees operate a facility owned van, they have inherent responsibilities to care for the vehicle and the residents, obey all state and local traffic laws, and abide by established driver operating procedures. Employees must practice safe driving procedures and obey the rules of the road when operating a facility owned van. b. Secure seat belts anytime the vehicle is in motion and require all passengers to wear seatbelts. c. Ensure all residents and wheelchairs are safely secured."

On 6/15/24 at 9:15 AM R1 was sitting in wheelchair in the dining room. R1 stated, "(V10/Maintenance Assistant) was bringing me home from the wound clinic (on 4/25/24) in the facility van and slammed on the brakes. I fell forward out of my wheelchair and hit my head on the seat in front of me. My shoulders and neck were hurting from hitting them on the seat. I thought I was paralyzed. I was so scared since I am already paraplegic. (V10) did not seat belt me in right. It hurt my neck and shoulders and I was taken to the hospital to make sure I was okay."

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 06/17/2024

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
S9999	Continued From page 13	S9999		

R1's Medical Record does not include documentation of R1 having a fall while in the van on 4/25/24 and does not include an investigation into the root cause of R1's fall or the implementation of new fall interventions to prevent further falls.

R1's current Care Plan does not address R1's fall on 4/25/24.

On 6-15-24 at 9:45AM V10 (Maintenance Assistant) stated, "On (4/25/24) I had to take (R1) to the wound clinic and had never driven the van before. While on the interstate the stop light switched quickly to red, and I had to hit the brakes quick. I did not check to make sure the d-ring was clamped onto the back of (R1's) seat belt. The d-ring keeps (R1's) seat belt secured. R1 fell face first and hit his head on the back of the seat. (R1) said he could not move his arms or chest or anything. After we went a little farther (R1) could feel his hands again. I took R1 into the emergency room there (in the same town) and asked the nurses to get (R1) off the floor and assess him. (R1) did not have any injuries. (V7) asked me to take (R1) to her house for the night. This was the first time I transported a resident in the facility van. I was not trained prior to transporting (R1) in the van on how to properly buckle residents in wheelchairs in the van or use the d-rings or seat belts in the van."

On 6/15/24 at 1:10 PM V1 (Administrator-In-Training) stated, "I cannot find evidence of an investigation being completed after (R1's) fall on 4/25/24. I had (V10) pick (R1) up from the wound clinic on 4/25/24. I did not realize (R1) was not trained on securing the residents in the van."

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 06/17/2024

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
S9999	Continued From page 14 (A)	S9999		