STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TAYLORVILLE SKLD NUR & REHAB	**800 MCADAM DR TAYLORVILLE, IL 62568**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to monitor for signs and symptoms constipation (i.e. bowel signs and consistency of bowel movements) per resident's plan of care for two of two residents (R3) reviewed for constipation in the sample of 6. Findings include: 1.R3's Electronic Health Record (EHR), documents R3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R3's Physician order [REDACTED]. R3 was receiving [MEDICATION NAME] from 6/17/20 until time of discharge on 6/28/20. Both medications are pain medications with side effects of constipation. R3's Minimum Data Set ((MDS) dated [DATE] documents R3 as cognitively intact, requires extensive assist of two persons for bed mobility and dressing, and is frequently incontinent of bladder and bowel. R3's Care Plan Problem, with initiating date of 6/21/20 documented she dehydration or potential for fluid deficiency elated to poor intake and history of urinary tract infection and aspiration pneumonia. The Interventions for this problem document that staff should monitor/document bowel sounds and frequency of BM (bowel movement) and provide medications as ordered. R3's Care Plan Problem, initiated on 6/21/20 documented R3 has constipation related to diminished appetite, chronic idiopathic constipation. The Interventions documented follow the facility's bowel protocol for bowel management. The Interventions documented to monitor/document/ report small loose stools, fecal smearing, bowels sounds tenderness guarding and rigidity of the abdomen. The Care Plan documented record bowel movement patter each day. Describe amount, color and consistency. R3's B&B (bowel and bladder function) Reports for 6/12-6/28/20 documents R3 had a bowel movement on 6/12, 6/13/20. There was no documentation R3 had bowel movements from 6/13-6/21/20. The Report documented that on 6/21, 6/22, 6/25, 6/26, 6/27 and 6/28/20. R3 had bowel movements. This report documented only the size R3's bowel movement. The report did not document the color and consistency of R3's bowel movements. R3's Progress Notes, from 6/21/20 through 6/27/20, did not document the facility was monitoring R3's bowel sounds or consistency of bowel movements. R3's Progress Note, dated 6/27/20 at 8:07 AM documented R3 had vomiting and diarrhea continuously. The Note documented the vomit has a brown tint and her abdomen was very distended and tender. R3's Transfer/Discharge Report dated on 6/27/20 at 9:00 PM documents that R3 was sent out to local hospital. R3's Progress note, dated 6/28/2020, documents, Resident transferred to hospital r/t (related to) bowel blockage and acute UTI. No call back received from POA (Power of Attorney) or MD (medical doctor) at this time, voicemail's left. On 9/14/2020 at 11:23 AM, V13, Speech Therapist, stated, (R3) was in bed largely due to pain, isolation due to COVID stuff. V13 stated, I think (R3) complained of constipation. On 9/15/2020 at 09:07 AM, V8, Registered/RN, stated, CNAs are responsible for documenting a resident's bowel movements (BM). On 9/15/2020 at 1:00 PM, V17, V19's (R3's Physician) Nurse, stated, Yes, we would expect the facility to follow through with a resident's care plan. On 9/15/2020 at 3:20 PM, V18, R3's daughter/POA (power of attorney) stated, My mom was in big pain. V18 stated, When I went to see her, she would always be in bed. V18 stated, My mom said her belly was hurting real bad, and she couldn't get up and move. V18 stated, I called the facility about my mother complaining about constipation and an unknown staff member advised that they had given her an enema and they were going to repeat the enema. V18 stated, When I called back, unknown staff member stated that the enema they gave the day before worked so they didn't have to repeat. Facility's Policy and Procedure 'Bowel Regimen' dated 9/15/20 documents: Purpose: To provide guidelines to staff for implementing a bowel regimen that will assist in obtaining and maintaining normal bowel patterns. Policy: Bowel regimen may be initiated by Head/Charge Nurse with the written approval of the attending physicians. The Policy and Procedure documented 6. Continue supervision of resident. Notify physician if no results are obtained. 7. Change in color and consistency should be noted in Nurse's Notes in resident chart and notify physician if appropriate.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide assistance with eating and a dining environment which is conducive to safe swallowing and enhancing intake for one of three residents (R2) reviewed for Nutritional Maintenance in the sample of 6. Finding includes: R2's Electronic Health Record (EHR) documents R2 is an [AGE] year-old male admitted to the facility R2's Minimum Data Set ((MDS) dated [DATE] documents R2 to be severe cognitively impaired with a Brief interview of Mental Status (BIMS) score of 6. The MDS documents R2 requires extensive assist of two persons for bed mobility. The MDS documents that R2 requires assistance of 1 staff member for eating. R2's Care Plan dated [DATE] documents: Self-Care Deficit as Evidenced by: Needs assistance with ADLs (Activities of Daily Living) Related to Weakness, [MEDICAL CONDITION], failure to thrive, due to condition prefers to stay in bed. The Care Plan documented INTERVENTIONS: Eating - One-person physical assist required. On [DATE] at 9:44AM, R2 was lying in bed with the head of bed down reaching out and scraping at the breakfast tray that was located on the bedside table alongside bed. V9 Certified Nurse's Assistant (CNA) stated, (R2) puts the head down of bed down by himself. V9 CNA attempted to raise R2's head of bed up and R2 hollered out in pain. V9 CNA stated, We'll tell the nurse. On [DATE] at 10:05 AM V5 Nurse Supervisor stated, (R2) had a (High boy) chair that he used to get out of bed. V5 stated the chair R2 used belonged to another resident. V5 stated when that residents expired, the family came and took the chair away so R2 couldn't use it. V5 stated, We did order (R2) his own chair last week, because I wasn't aware that chair didn't belong to (R2). On [DATE] at 10:13 AM R2 was in his bed with the head of bed down. R2's breakfast tray remains on bedside table alongside of bed. No staff present to assist R2 with meal. R2 stated, I would like to get out of bed into a chair and go outside. On [DATE] at 12:09 PM R2 was in bed with the head of bed down, with bedside table alongside of bed with meal tray. R2 was attempting to eat. No staff present assisting R2 with meal. On [DATE] at 12:45 PM V2 Director of Nursing (DON) stated, I have been here 3 weeks now. V2 stated, I'm not going to lie. V2 DON stated, I was unaware that (R2) didn't have a (high boy) chair until the family came and picked it up and (R2) asked me to get him up. V2 DON stated, I called the CNA's and they stated they had no chair to put him in. V2 DON stated, I looked and found 2 wheelchairs, but he didn't fit in either one. V2 DON stated, We have nothing for him, but ordered one last week for him. R2's Vital weight dated [DATE] documents R2 weighed 201 pounds. R2's R2's Vital weight dated [DATE] documents R2 weighed 172.6 pounds. R2's Progress note dated [DATE] General Note documents Doctor (Dr) notified of weight loss. continue with med pass as ordered. staff educated on helping resident with meals. On [DATE] at 1:00 PM V18, V19 (Physician's) Nurse, stated, Yes, we would expect the facility to follow through with a resident's care plan. Facility's Policy and Procedure 'Feeding the Dependent Resident' dated [DATE] documents: Residents who require assistance with feeding will receive needed assistance from nursing staff. The Procedures continues Responsibility: It is the responsibility of the Nursing Staff to ensure that all residents who require assistance with feeding receive the needed assistance. The Policy and Procedures documents It is the responsibility of the Care Plan Coordinator to properly assess all residents and identify those that require assistance with feeding on their care plan. Procedure: Take tray to resident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TAYLORVILLE SKLD NUR & REHAB	**800 MCADAM DR TAYLORVILLE, IL 62568**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) B. Place tray directly in front of resident. C. Assist resident to proper sitting position unless contraindicated.