STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145442	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Toulon Rehab & Health Care Center	Highway 17 East Toulon, IL 61483

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38805 Based on record review and interview, the facility failed to revise a Comprehensive Care Plan for one resident (R1) of three residents reviewed for Care Plan revision in a sample of three. Findings includes: The facility's Comprehensive Care Plan Policy dated 11/1/17 documents: It is the policy of (Facility) to comprehensively assess and periodically reassess each resident admitted to this facility. The results of this resident assessment shall serve as the basis for determining each resident's strengths, needs, goals, life history and preferences to develop a person centered comprehensive plan of care for each resident that will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1.b. The Care Plan shall be revised as necessary when the needs/problems and care and services specified in the plan of care no longer reflect those of the Resident. The facility's Resident Monitoring Policy, undated, documents: (Facility) may initiate monitoring of residents as nursing measure to assist in providing safety to residents that are identified to be a potential threat to self or others or an elopement risk. 1. Assess resident and document for need for monitoring. R1's Wandering-Elopement Evaluation Scale, dated 12/11/23 documents: Score 10, At risk to wander/exit seek. J. Scoring: 0-8 Low Risk; 9-10 At Risk to Wander; 11-Above High Risk to Wander. R1's current Care Plan documents: The resident has impaired cognitive function/dementia or impaired thought processes related to dementia, impaired decision making. R1's current Care Plan does not document care plan goals or interventions for R1's wandering and elopement concerns. On 5/2/24 at 1:58pm, V10 Certified Nursing Assistant/CNA stated: Sometimes (R1) would say something about wanting to go home or calling her sister. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5//2/24 at 1:35pm, V8 Licensed Practical Nurse/LPN stated ,I have been here [AGE] years, we follow elopement protocol. (R1) has tried to exit seek and every day we intervene to redirect her. She exit seeks but we try to redirect before it gets that far; she will verbalize and say I want to leave. On 5/2/24 at 12:50pm, V1 Administrator stated that R1's Care Plan Should reflect something about (R1's) wandering and exiting the building; but it does not and should. On 5/2/24 at 12:55pm, V1 Administrator and V2 Director of Nursing/DON stated that whenever there is a change of condition per the Care Plan policy, the Care Plan should reflect the changes; and stated that R1's Care Plan does not have any mention of her wandering or trying to leave. V1 stated, Generally the management team sits down and every morning do updates. Definitely her (R1's) Care Plan should have been updated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38805 Based on interview and record review, the facility failed to provide supervision to prevent a fall for one (R1) resident of three residents reviewed for accidents/supervision in a sample of three. Findings include: The facility's Fall Prevention Policy, Revised 11/10/18, 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. All staff must observe residents for safety. The facility's Resident Monitoring Policy, undated, documents: (Facility) may initiate monitoring of residents as nursing measure to assist in providing safety to residents that are identified to be a potential threat to self or others or an elopement risk. 1. Assess resident and document for need for monitoring. R1's AIM (Assess, Intercommunication, Manage) for Wellness Communication Form dated 4/12/24 documents: Resident was sitting in the dining room eating supper just prior to/at the time of the event; Resident got up unassisted, went out A-Hall Exit door, falling onto the cement outside A-Hall door. Event first noted at (5:50) pm. R1's 4/12/24 Progress Note documents: (Licensed Practical Nurse/LPN) was immediately notified of fall; LPN went to A-hall exit door, noted (R1) on ground laying on back on the cement sidewalk outside. Door alarm was going off which is why (Certified Nursing Assistant) immediately went to A-hall exit door. R1's Wandering-Elopement Evaluation Scale, dated 12/11/23 documents: Score 10, At risk to wander/exit seek. J. Scoring: 0-8 Low Risk; 9-10 At Risk to Wander; 11-Above High Risk to Wander. R1's Fall Risk Evaluation dated 12/11/23 documents R1's Score at 17; At Risk; and History of falls. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has a BIMS (Brief Interview of Mental Status) score of 3. (MDS indicates that on a scale of 0 - 15, 13 to 15 cognitively intact; 8 to 12 moderate impairment; and 0 to 7 severe impairment.) R1's current Care Plan documents: The resident has impaired cognitive function/dementia or impaired thought processes related to dementia, impaired decision making. The resident review shows risk for falls, risk factors include: Confusion, deconditioning, gait/balance problems, history of falls, dementia. R1's diagnoses included: Dementia, mood disorder due to known physiological condition with depressive features, cataract extraction status, history of falling. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 1:58pm, V10 Certified Nursing Assistant/CNA stated that sometimes (R1) would say something about wanting to go home or calling her sister; and on 4/12/24, all of the CNAs were in the dining room at the time of R1's fall feeding residents around 6:00pm and heard a door alarm going off. V10 stated, Usually the nurses are monitoring the halls at nursing station, but the nurse was still passing meds at that time and was in the dining room as well. I did not see (R1) leave the dining room; she was there for dinner. Did not notice she was not there. On 5/2/24 at 1:50pm, V9 CNA indicated that that she worked on 4/12/24 at the time of R1's fall incident; stated that no one was assigned to be on the floor during mealtimes; no one was on the floor to supervise; and all the staff were in the dining room feeding and passing trays. V9 stated, All CNAs are supposed to be in the dining room passing trays and feeding. This has been like this for years. No one was monitoring or supervising R1. No one on the floors to monitor residents who were not in the dining room or those who left. On 5//2/24 at 1:35pm, V8 Licensed Practical Nurse/LPN stated that on 4/12/24 at supper time, she was doing med pass; girls feeding, heard the alarm. Stated that staff went to check the door (A-Hall). V8 stated that this has happened before, and staff respond to alarm and intervene and attempt to keep residents from exiting; stated that 90 percent of the residents are in the dining room during mealtimes. V8 stated, I have been here [AGE] years, we follow elopement protocol. (R1) has tried to exit seek and everyday we intervene to redirect her. She exit seeks but we try to redirect before it gets that far; she will verbalize and say I want to leave. On 5/2/24 at 12:50pm. V2 Director of Nursing/DON stated: One CNA is supposed to be monitoring the halls at all times during meals, while the others were feeding in the dining hall. On 5/2/24 at 12:55pm, V1 Administrator stated: Staff should have kept an eye on all residents. All residents should be supervised and monitored all the time for safety; normally (R1) is always out with us at nursing station and comes to be with management. She is usually not in the room by herself, once she comes out, she is with you. (R1) should have been supervised and we should know where residents are at all times.