STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145502	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taylorville Care Center	600 South Houston Taylorville, IL 62568

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Base on interview and record review, the facility failed to notify the Physician of high blood sugar results and a newly acquired pressure ulcer for 2 of 17 residents (R14, R51) reviewed for Physician notification in the sample of 44. Findings include: 1. R51's Face Sheet, undated, documents that R51 was admitted on [DATE] and has diagnoses of Type 2 Diabetes mellitus, Depression and Anxiety. R51's Minimum Data Set (MDS), dated [DATE], documents that R51 is cognitively intact. R51's Physician Orders, documents, Humulin 70/30 U-100 Insulin suspension; 100 unit/mL (milliliter) (70-30); amt (amount): 65; subcutaneous Once A Day Evening 03:00 PM - 06:00 PM. Discontinue date of 6/8/24. R51's Physician Orders, documents, Humulin 70/30 U-100 Insulin suspension; 100 unit/mL (70-30); amt: 70; subcutaneous Once A Day Morning 06:00 AM - 10:00 AM. Discontinue date of 6/8/24. R51's Physician Orders, dated 6/8/24, documents, Humulin 70/30 U-100 Insulin suspension; 100 unit/mL (70-30); amt: 70; subcutaneous Once A Day Evening 03:00 PM - 06:00 PM. R51's Physician Orders, dated 6/8/24, documents, Humulin 70/30 U-100 suspension; 100 unit/mL (70-30); amt: 75; subcutaneous Once A Day Morning 06:00 AM - 10:00 AM. R51's Physician Orders, dated 7/20/23, documents, Accu Check Special Instructions: Call MD if <70 or >260 Twice a day; Morning 6:00 AM - 10:00 AM, Evening 3:00 PM - 6:00 PM. R51's Blood Sugar Log, dated 5/8/24 - 6/4/24 documents 21 times that R51's blood sugar was over 260. R51's Progress Notes from 5/8/24 - 6/4/24 failed to document V32 (R51's Physician) being notified of high blood sugars. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 1:50 PM, V22, Registered Nurse (RN), stated, (R51) does have orders to call the doctor if his blood sugar is over 260. It should be documented in the progress notes that the Doctor was notified. I will tell you, I don't call the Doctor much because 260 is not that high. If it is high then I will call him. V22 was questioned what she considered high, V22 stated, 300 but that isn't an excuse we should be calling the doctor if it is ordered. On 6/10/24 at 12:40 PM, V8, Licensed Practical Nurse (LPN) stated, I do call V32 (R51's Physician) when his blood sugar is high. I would chart it in the progress notes. It has been quit awhile since I have notified him though. On 6/10/24 at 12:35 PM, V4, Assistant Director of Nurses (ADON), stated, Sometimes I will call (R51's Doctor) and let him know that R51's blood sugar is high and sometimes I forget. If I did call, I would chart it in the progress note. On 6/10/24 at 12:43 PM, V32, R51's Physician, stated, I was not aware that R51 blood sugars were running high. It is really sad. I went in to do rounds on Saturday (6/8/24) and asked for them to print me a print out of his blood sugars. He is consistently running high and I was unaware. I increased his insulin for both doses on Saturday since I found this out. It didn't cause him harm it just slows things down. 40701 2. R14's Braden Score for predicting Pressure Sore Risk, dated 5/9/2024, documents that R14 is constantly moist, chairfast, and has very limited mobility to makes changes in body positioning. It further documents that R14 is at moderate risk for pressure ulcer development. R14's Wound Summary Report, dated 5/1/2024-6/6/2024, documents that R14 acquired a stage 3 pressure ulcer to R14's left buttock, that was not present upon admission. If further documents, that it was identified on 4/30/2024. R14's Wound Management Detail Report, dated 4/30/2024, documents that the area was a stage 3 pressure ulcer and measured 2 x 1.5 x 0.1 centimeters. There were no other measurement listed prior to this measurement completed by V2 (Director of Nurses). R14's Progress Notes, dated 4/15/2024, documented, CNA (Certified Nurses Aide) brought it to my attention during bed check that resident has an open area on her left buttock. The area was cleaned, and ointment was put on the area. It does not document if the physician was notified, the wound was measured, or if an order was obtained. R14's Progress Notes, dated 4/30/2024, documented, Resident with area to left inner buttock, see wound management entry for measurements and details. Treatment order inserted for Medi honey, calcium alginate and border gauze dressing daily and PRN (as needed). Treatment applied by writer at this time. Offloading and frequent repositioning to be continued as resident is total assist and (mechanical) lift. MD (Medical Director) and POA (Power of Attorney) updated. On 6/6/2024 at 11:04 AM, V2 stated that R14's wound was first identified on 4/15/2024, but V2 was not made aware of it until 4/30/2024 when a CNA showed her. V2 also stated that the order obtained on 4/30/2024 was the first order received for the wound and the first time it was measured. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/1024 at 12:01 PM, V2 stated, I would have expected the nurse who found the open area to call the doctor, get an order and I would have seen her on wound rounds. Change in a Resident's Condition or Status Policy, dated 11/16, documented, Procedure: i. Instructions to notify the physician of changes in the resident's condition.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview and record review, the facility failed to prevent verbal abuse for 1 of 17 residents (R51) reviewed for abuse in the sample of 44. Findings include: On 6/3/24 at 11:12 AM, R51 stated, Not to long ago an aide came in to give me a bed bath. She took the tub of water and poured it directly on me. I have never had a bed bath like that before. I told her that and she didn't seem to care. Then on Friday around noon she had came in here. I had asked her to do something and she didn't want to. I admit I should not have said it but I told her You work for me. She came back with No I don't work for you. I work for the company. I did not like that. She then left my room and while she was out in the hall I heard her tell the other aide He is such an axxxxxe. She shouldn't be saying that to others. R51 was questioned about who the aide was, R51 stated, I don't know her name. She is newer. She is a larger woman with curly black hair. I am not sure if she is African or a mixed race but she has darker skin tone. R51 was questioned if he told anyone about these incidents, R51 stated, I told my wife but not any workers. On 6/3/24 at 11:50 AM, V1, Administrator, was notified of the allegations of abuse. On 6/3/24 at 3:45 PM, V1 stated that she had started an investigations into the allegations of abuse. On 6/4/24 at 11:58 AM, V1 stated, I have spoke with (R51) and (V18, Certified Nurses Aide, CNA). They both told the same story. (R51) did not want to get out of bed for a shower. He has a treatment that goes on his back. The aides told him that his back needed to be washed before the nurse could put the treatment on. Since he did not want to get up they gave him a bed bath. He was rolled over and with the wet washcloths she (V18) wrung them out over his back. She did not pour the bucket of water over him. (R51) told me the same thing. When I asked him specifically if she threw a bucket of water on him he said no she wrung the rags but what is the difference. (V18) admitted when she was leaving the room that she told the other aide He is being an axxxxxe. She was not able to work yesterday and she is currently suspended. I did report the allegation of abuse to the IDPH. On 6/10/24 at 12:09 PM, V1, stated that the final report is due today and it not completed yet. V1 stated that she is going to substantiate the allegation of abuse. V18's written statement related to R51's abuse allegation, dated 6/3/24, documents, Under my breathe, or so I thought. I told the other aideThis is why I didn't want to do him yet. He's acting like an axxxxxe. He heard me and wanted management. So I got the nurse (V8) and told (V4, Assistant Director of Nurses) exactly what happened. R51's Face Sheet, undated, documents that R51 was admitted on [DATE] and has diagnoses of Type 2 Diabetes mellitus, Depression and Anxiety. R51's Minimum Data Set, dated dated [DATE], documents that R51 is cognitively intact. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse Prevention Policy, dated 9/29/22, documents, Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. It continues, mistreatment means inappropriate treatment or exploitation of a resident. It continues, 5. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect immediately to the administrator. It continues, 7. Internal investigation of abuse, neglect or misappropriation allegations and response. a. All incidents will be documented, whether or not abuse occurred, was alleged or suspected. b. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on interview and record review, the Facility failed to ensure their Abuse Prevention Policy was followed/implemented for 2 of 24 residents (R50, R51) reviewed for abuse/neglect, in the sample of 34. Findings include: 1. On 6/3/2024 at 3:30 PM, V9, Registered Nurse (RN) stated, I overheard a CNA (Certified Nursing Assistant) call a resident an axxxxxe. I just heard about it a minute ago. I know (V18, Certified Nurse Aide (CNA) was on the schedule but she has been suspended. On 6/4/2024 at 9:10 AM, V5, R50's daughter, stated, (R50's) roommate said someone called mom a fxxxxxg bxxch. If it was just mom saying it I might not think too much about it because sometimes she's not in her right mind. I confronted staff and talked to (V1, Administrator). She just said, 'Oh none of our employees would say that'. Mom and (R58) both swore it happened. It just got blown off. On 6/4/24 at 3:07 PM, Both R50 and R58 stated that R50 was called a fxxxxxg bxxxh. R58 stated the staff member was (V19, CNA) and R58 told V22, RN. On 6/4/2024 at 3:25 PM, V2, Director of Nursing (DON), stated, Nobody told me about it. I just heard. (V9, RN) was in the hallway. Someone said (R58) thought she heard it, but (R58) is on hospice and has confusion. We thought maybe she (the staff member) was calling someone else that. (V1) is the abuse coordinator. I report to her and she does the report. On 6/04/24 at 03:19 PM V1, Administrator (ADM) denied knowledge of the allegation of a staff member calling R50 a fxxxxxg bxxxh. On 6/6/2024 at 9:11 AM V1 stated, No one came to me about it. On 6/6/2024 at 9:27 AM, V2 stated, I did heard about it. I was told in report when I was taking over for (V9, Registered Nurse). He said he was standing right outside the door but did not hear it. (R58) was be confused and hallucinates so I wondered if she just thought she heard it. I just didn't think too much about it. On 6/6/2024 at 10:39 V5 stated she spoke to (V9) and made him aware of the allegation. On 6/6/24 at 11:08 AM, V21, R50's daughter and Power of Attorney, stated, I went to visit mom the other day. She was in a foul mood. I asked her what was wrong. She said, 'I'm not going to have those people in here calling me a fxxxxxg bxxxh. I don't know the name. I asked (R58, R50's roommate) and she said, 'I wouldn't want them taking to me like that'. I questioned the nurse, (V9, RN), about it. I told him I confirmed it with mom and (R58). Sometimes a lot of the people working there don't have any empathy. I would think if you report something like that it should be investigated. 33112 (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 6/3/24 at 11:12 AM, R51 stated, Not to long ago an aide came in to give me a bed bath. She took the tub of water and poured it directly on me. I have never had a bed bath like that before. I told her that and she didn't seem to care. Then on Friday around noon she had came in her. I had asked her to do something and she didn't want to. I admit I should not have said it but I told her You work for me. She came back with No I don't work for you. I work for the company. I did not like that. She then left my room and while she was out in the hall I heard her tell the other aide He is such an axxxxxe. She shouldn't be saying that to others. R51 was questioned about who the aide was, R51 stated, I don't know her name. She is newer. She is a larger woman with curly black hair. I am not sure if she is African or a mixed race but she has darker skin tone. R51 was questioned if he told anyone about these incidents, R51 stated, I told my wife but not any workers. On 6/3/24 at 11:50 AM, V1, Administrator, was notified of the allegations of abuse. On 6/3/24 at 3:45 PM, V1 stated that she had started an investigations into the allegations of abuse. On 6/4/24 at 11:58 AM, V1 stated, I have spoke with (R51) and (V18, Certified Nurses Aide, CNA). They both told the same story. (R51) did not want to get out of bed for a shower. He has a treatment that goes on his back. The aides told him that his back needed to be washed before the nurse could put the treatment on. Since he did not want to get up they gave him a bed bath. He was rolled over and with the wet washcloths she (V18) wrung them out over his back. She did not pour the bucket of water over him. (R51) told me the same thing. When I asked him specifically if she threw a buck of water on him he said no she wrung the rags but what is the difference. (V18) admitted when she was leaving the room that she told the other aide He is being an axxxxxe. She was not able to work yesterday and she is currently suspended. I did report the allegation of abuse to the IDPH. On 6/6/24 at 11:45 AM, V6, Certified Nurses Aide (CNA), stated that V18 did call R51 an axxxxxe but that it was outside the door and she did not believe that R51 heard V18 and that is the reason she did not report the incident to V1. On 6/10/24 at 12:09 PM, V1, stated that the final report is due today and it not completed yet. V1 stated that she is going to substantiate the allegation of abuse. On 6/10/24 at 12:39 PM, V4 Assistant Director of Nurses, stated that she was never told of the allegation that V18 called R51 an axxxxxe. On 6/10/24 at 12:40 PM, V8, stated, I let (V2, Director of Nurses) know. I had spoken to (V1, Administrator) earlier in the morning and she let me know that she was in Chicago and if I had any problems to let V2 know and take care of it. On 6/10/24 at 1:00 PM, V2 stated, I was told that (R51) wanted to talk to me. I was not in the building for long. I forgot to go and talk to him. I was not told what he wanted to talk to me about. V8's Licensed Practical Nurse (LPN's) written statement related to R51's abuse allegation, dated 6/3/24, documents, (V6) came and told me (R51) was refusing care and wanted to talk to her. I went down there he didn't like their attitudes. (V18) conversation with other girl and said he was acting like an axxxxxe. I told him I'd let (V2, Director of Nurses) know and could she come and talk to him. (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V18's written statement related to R51's abuse allegation, dated 6/3/24, documents, Under my breathe, or so I thought. I told the other aideThis is why I didn't want to do him yet. He's acting like an axxxxxe. He heard me and wanted management. So I got the nurse (V8) and told (V4, Assistant Director of Nurses) exactly what happened. V20's, CNA, written statement related to R51's abuse allegation, dated 6/3/24, documents, (R51) started telling me he was going to turn in a dark skinned person for calling him an axxxxxe. R51's Face Sheet, undated, documents that R51 was admitted on [DATE] and has diagnoses of Type 2 Diabetes mellitus, Depression and Anxiety. R51's Minimum Data Set, dated dated [DATE], documents that R51 is cognitively intact. The Abuse Prevention Policy, dated 9/29/22, documents, 5. Internal Reporting Requirements and Identification of Allegations: Employees are required to report any incident, allegation, or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about, or suspect immediately to the administrator. It continues, 7. Internal investigation of abuse, neglect or misappropriation allegations and response. a. All incidents will be documented, whether or not abuse occurred, was alleged or suspected. b. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation.

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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** 40701 Based on interview and record review, the facility failed to ensure standards of care were implemented for a resident with a diagnosis of diabetes by not monitoring blood sugars for 1 of 3 residents (R50), reviewed for quality of care, in the sample of 44. Findings include: R50's Face Sheet, dated 6/5/2024, documents that R50 has a diagnosis of Type 2 Diabetes Mellitus (DM) and was admitted to the facility on [DATE]. R50's Care Plan, dated 4/18/2024, does not address R50's diagnosis of Diabetes. R50's Physician's Order Sheet (POS), dated 12/29/2024-6/6/2024, documents that Accu checks (blood glucose monioring) before meals and at bedtime were ordered on 6/5/2024, but had not been being completed prior to that date. R50's POS also documents that R50 has been on insulin since her admission on 12/29/2024, with the exception of 5/29/2024 until 6/5/2024, when R50's insulin was unintentionally omitted. On 6/3/2024 at 3:30 PM, V9, Registered Nurse (RN), stated that he doesn't think R50 is currently getting her blood sugars taken. On 6/10/24 at 1:44 PM V1, Administrator (ADM), stated that R50 admitted to the Facility in December of 2023. V1 stated When we noticed the insulin we also saw she wasn't getting accu checks (measuring blood sugar levels) and she should have been. On 6/10/2024 at 1:52 PM, V2, Director of Nursing (DON), V4 Assistant Director of Nursing (ADON) and V22, Registered Nurse all stated that it is standard of care that if a resident is on insulin and has diagnosis of diabetes, their blood sugars/accu checks should be monitored regularly.

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	145502	A. Building B. Wing	06/10/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40701 Based on interview, observation and record review, the Facility failed to prevent, identify, obtain orders and monitor pressure ulcers for 2 of 3 residents (R14 and R71) reviewed for pressure ulcers, in the sample of 44. This failure resulted in R14 going from 4/15/2024 until 4/30/2024 without treatment for or monitoring of a stage 3 facility acquired pressure ulcer. Findings include: 1. R14's Braden Score for predicting Pressure Sore Risk, dated 5/9/2024, documents that R14 is constantly moist, chairfast, and has very limited mobility to makes changes in body positioning. It further documents that R14 is at moderate risk for pressure ulcer development. R14's Progress Notes, dated 4/15/2024, documents, CNA (Certified Nurse Assistant) brought it to my attention during bed check that resident has an open area on her left buttock. The area was cleaned, and ointment was put on the area. It does not document if the physician was notified, the wound was measured, or an order was obtained. R14's Wound Summary Report, dated 5/1/2024-6/6/2024, documents that R14 acquired a stage 3 pressure ulcer to R14's left buttock, that was not present upon admission. If further documents, that it was identified on 4/30/2024. R14's Wound Management Detail Report, dated 4/30/2024, documented that the area was a stage 3 pressure ulcer and measured 2 x 1.5 x 0.1 centimeters. There were no other measurement listed prior to this measurement completed by V2, Director of Nurses (DON). R14's Progress Notes, dated 4/30/2024, documents, Resident with area to left inner buttock, see wound management entry for measurements and details. Treatment order inserted for Medi honey, calcium alginate and border gauze dressing daily and PRN. Treatment applied by writer at this time. Offloading and frequent repositioning to be continued as resident is total assist and (mechanical) lift. MD (Medical Director) and POA (Power of Attorney) updated. R14's Minimum Data Set (MDS), dated [DATE], documents that R14 is dependent on staff for rolling left to right and is always incontinent of bowel and bladder. R14's Care Plan, dated 10/12/2022, documents that R14 has full bowel and bladder incontinence and the goal is that R14 will remain free from skin breakdown due to incontinence. It further documents, My nurse will provide a head to toe skin assessment daily. It continues, CNA staff will also observe for new or developing areas during routine care and with scheduled bathing. On 6/6/2024 at 11:04 AM, V2, DON, stated that R14's wound was first identified on 4/15/2024, but V2 was not made aware of it until 4/30/2024 when a CNA showed her. V2 stated the order obtained on 4/30/2024 was the first order received for the wound and the first time it was measured. On 6/10/1024 at 12:01 PM, V2 stated, I would have expected the nurse who found the open area to call the doctor, get an order and I would have seen her on wound rounds. (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	33112 2. On 6/4/24 at 1:58 PM, V4, Assistant Director of Nurses (ADON), stated that she just completed R71's pressure ulcer dressing. The right foot dressings, right inner thigh, left gluetal fold, and right upper buttocks were observed, in place and dated 6/4/24. V4 stated all are treated with medihoney and border gauze dressings. On 6/6/24 at 9:07 AM, V7, CNA and V20,CNA both donned gowns and gloves and entered R71's room to transfer R71 from the wheelchair to the bed. R71's incontinent brief was removed and a skin check was done. R71's left buttock gluetal fold area has a pressure ulcer about the size of a dime. The wound bed is dark pink with a small open area in the center. R71's right upper buttocks has pressure ulcer the approximate size of nickel. The wound bed is dark pink with a small open area in the center. Neither of these pressure ulcers have a dressing on them. R71's right foot has three dressings (inner ankle, left outer heel, and medial foot) in place that are dated 6/6/24. The right foot has no pressure ulcers. R71 was positioned on his back leaning to the right side with a blanket between his knees, and a pillow under his left side. R71's left foot was positioned over his right inner heel where the pressure ulcer is located. R71 did not have heel boots on. R71 was covered up and given the call light. On 6/6/24 from 9:07 AM - 11:55 AM, R71 has remained in the same position without the benefit of offloading based on 15 minute observations. On 6/6/24 at 11:55 AM, V2, DON, and V4, ADON, entered R71's room. Both were wearing gowns and gloves. V4 removed the old dressing on the right medial foot, sprayed it with wound cleanser, applied medi-honey to a bordered gauze and placed the gauze on the pressure ulcer. The pressure ulcer is the approximate size of a dime, the wound bed is 100% slough, and the peri-wound is light pink in color. V4 removed the old dressing from the right outer heel. The pressure ulcer is approximately 3 centimeter (cm) x 2 cm. The wound bed is 95% slough. The peri-wound is light pink in color. V4 cleansed with wound cleanser, applied medi-honey to a bordered gauze and placed the gauze on the pressure ulcer. V4 then removed the dressing to the right outer ankle. The pressure ulcer is the approximate size of a dime. The wound bed is yellowish slough. The peri-wound is light pink in color. V4 cleansed with wound cleanser, applied medi-honey to a bordered gauze and placed the gauze on the pressure ulcer. V4 never changed gloves between the 3 pressure ulcer changes. R71 was rolled over onto his right side. The left gluetal fold pressure ulcer did not have a dressing on it. R71's incontinent bed pad was wet with urine. The pressure ulcer is approximately the size of a dime. The wound bed is dark pink with a small open area in the center. V4 placed medi-honey on a bordered gauze pad and placed it on the pressure wound. V4 failed to cleanse the wound before applying the treatment. At this time, V4 was questioned if she was going to treat R71's right upper buttocks, V4 stated, I think that is healed. V4 was informed that the wound was open this morning. V4 stated, It has been closed for awhile now. V4 was informed that the pressure ulcer dressing was observed with her on 6/4/24, V4 stated, That's right it did have a dressing on it. R71's right upper buttocks has pressure ulcer the approximate size of nickel. The wound bed is dark pink with a small open area in the center. V4 cleansed the wound with wound cleanser, applied medi-honey and then a bordered gauze. On 6/6/24 at 12:05 PM, V2 and V4 both were questioned why R71 does not have heel protectors on, V2 stated, He used to have a pair. I don't know where they are. I will get him a pair. V2 and V4 both agreed that the way R71 lays in bed his left foot lays directly over the right heel pressure ulcer and he should be turned every 2 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145502	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Taylorville Care Center	600 South Houston Taylorville, IL 62568

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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 0686 Level of Harm - Actual harm Residents Affected - Few	R71's Face Sheet, undated, documents that R71 was admitted on [DATE] with diagnosis of Hypertension, Type 2 Diabetes Mellitus, Unspecified Open Wound to right foot, and need for assistance. R71's MDS, dated [DATE], documents that R71 is moderately cognitively impaired, dependent on staff for toileting, and dependent on staff or requires maximum assistance from staff for all mobility. R71's Braden Scale for predicting pressure ulcers, dated 4/24/24, documents that R71 is at moderate risk of developing pressure ulcers R71's Physician Orders, dated 5/23/24, documents, Right Ischium-Cleanse and apply medi honey and border gauze daily and PRN (as needed) for soiling/dislodging. Once A Day Bedtime 06:00 PM - 06:00 AM. R71's Physician Orders, documents, Left Buttock-Cleanse, apply calcium alginate with silver and border gauze Daily and PRN for soiling/dislodging. Once A Day. Bedtime 06:00 PM - 06:00 AM. Start date of 04/20/2024. Discontinue Date of 06/03/2024. R71's Physician Orders, dated June 2024 reviewed 6/6/24 at 9:30 AM, fails to document a current order for treatment to R71's left upper buttocks. R17's Physician Orders, documents, Right Distal Medial Foot- Cleanse, apply medi honey and cover with border gauze daily and PRN for soiling/dislodging. Once A Day. Morning 06:00 AM - 02:00 PM. Start date of 5/8/24. R17's Physician Orders, documents, Right lateral Ankle- cleanse, apply medi honey, cover with border gauze daily and PRN for soiling/dislodging. Once A Day. Morning 06:00 AM - 02:00 PM. start date of 5/8/24. R17's Physician Orders, documents, Right Medial Heel-Cleanse, apply medi honey and cover with border gauze daily and PRN for soiling/dislodging. Apply pressure reducing boots. Once A Day. Morning 06:00 AM - 02:00 PM. start date of 5/8/24. R17's Physician Orders, documents, Right Ischium - Cleanse and apply medi honey and border gauze daily and PRN for soiling and dislodging. R17's Pressure Ulcer Detailed Report, dated 6/5/24, documents that R71's Right ankle lateral pressure ulcer measures 1.3 centimeters (cm) length (l) x 1.4 cm width (w) x 0.3 cm depth (d), with light serous exudate and the pressure ulcer is improving. R17's Pressure Ulcer Detailed Report, dated 6/5/24, documents that R71's Right Medial Heel pressure ulcer measures 1.8 cm l x 1 cm w x 0.1 cm d with light serous exudate and the pressure ulcer is improving. (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R17's Pressure Ulcer Detailed Report, dated 6/5/24, documents that R71's Right Buttock Ischium pressure ulcer measures 1 cm l x 1 cm w x 0.1 cm d with light serous exudate and the pressure ulcer is improving. R17's Pressure Ulcer Detailed Report, dated 6/5/24, documents that R71's top of foot Distal, Medial pressure ulcer measures 1.5 cm l x 1.2 cm w x 0.2 cm d with light serous exudate and the pressure ulcer is improving. R17's Pressure Ulcer Detailed Report, dated 5/30/24, documents that R71's left buttock pressure ulcer is healed. The facility Wound Management Program, dated 2/26/21, fails to document a procedure on dressing changes, replacing dressings that are missing, cleansing the wound before treatment and turning and positioning. .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49494 Based on observation, interview, and record review the facility failed to ensure wheelchair brakes were locked,a gait belt was utilized during transfers, and smoking was supervised for 4 of 7 residents (R38, R58, R61, R63), reviewed for accidents, in a sample of 44. Findings include: 1. R63's face sheet, dated 6/6/24, documented R63 was admitted on [DATE] with diagnoses of cerebral infarction, diabetes, unspecified abnormalities of gait and mobility, and CHF (congestive heart failure). R63's MDS (Minimum Data Set) dated 4/30/24 documented R63 has moderate cognitive impairment and requires partial/moderate assistance with bed to chair and chair to toilet transfers. R63's fall risk assessment, dated 6/2/24, documented R63 is at high risk for falls. R63's care plan, undated, documented that R63 is at risk for falls. The facility's Fall Prevention Protocol, signed by R63's POA (Power of Attorney), dated 4/30/24, documented, The program consists of the following: 1. Risk assessments are done on all residents to determine what assistive devices may be needed to help promote safety. It continues, make sure that wheelchairs are locked before resident gets up or sits down. On 6/6/24 at 10:25 AM, V14, CNA (Certified Nurse Assistant), and V24, CNA, transferred R63 out of her recliner and into her wheelchair. V24 placed a gait belt around R63's waist and V24 and V14 lifted R63 to a standing position. V24 and V14 then transferred R63 into her wheelchair. V24 and V14 failed to lock R63's wheelchair causing the wheelchair to move backwards during the transfer. V24 and V14 then transferred R63 onto the toilet. V24 and V14 did not lock R63's wheelchair prior to transferring her onto the toilet. 2. R38's face sheet, dated 6/6/24, documented that R38 was admitted to the facility on [DATE] with diagnoses of right above the knee leg amputation, CHF (congestive heart failure), peripheral vascular disease, osteoarthritis, muscle wasting and atrophy. R38's MDS, dated [DATE], documented that R38 is severely cognitively impaired and requires substantial/maximum assistance with transfers. R38's fall risk assessment, dated 5/15/24, documented R38 is at moderate risk for falls. R38's care plan, undated, documented that R38 is at risk for falls related to above knee amputation and history of right-side weakness related to old CVA (cerebral vascular accident). On 6/6/24 at 10:55 AM, V14, CNA and V15, CNA, placed a gait belt around R38's waist and then transferred R38 from her wheelchair onto the toilet. V14 and V15 failed to lock the wheelchair on both sides causing the wheelchair to move back during the transfer. (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/24 at 10:58 AM, V14, CNA and V15, CNA, then lifted R38 off the toilet and then transferred R38 into her wheelchair. V14 and V15 both failed to lock the wheelchair causing the wheelchair to move back during the transfer. On 6/10/24 at 9:45 AM, V1, Administrator, stated that she would expect the CNA's to lock the wheelchairs prior to transferring residents. On 6/10/24 at 9:52 AM, V15, CNA, stated they are supposed to lock both sides of the wheelchair before transferring a resident. On 6/10/24 at 9:57 AM, V6, CNA, stated that she always locks the wheelchair before transferring a resident into it or out of it. On 6/10/24 at 12:20 PM, V31, Corporate Nurse, stated that the CNA's are trained to lock the wheelchairs when transferring residents. The facility's Validation of Competency form, undated, documented, 3. While preparing the resident for transfers, are safe techniques demonstrated by: a. removing the leg rests. b. locking wheelchair wheels (if resident is moving to a wheelchair). The facility's fall prevention protocol, undated, documented make sure that wheelchairs are locked before resident gets up or sits down. 40701 3. On 6/3/2024 at 10:15 AM, R58 stated that she is allowed to smoke unsupervised and keep her cigarettes and lighter. At this time, there was a pack of cigarettes and lighter on R58's bedside table. R58's Care Plan, undated, documented, Problem: I wish to smoke cigarettes and have been assessed. Approach: Nursing to keep cigarettes and lighter/matches in safe area. R58's Smoking Risk Assessment, dated 2/12/2024, documented that R58 is a safe smoker and to follow facility policy. On 6/4/2024 at 12:56 PM, V17, Social Service Director (SSD), stated, Smoking assessments are supposed to be done quarterly. The last one was done in February. I am in charge of updating the care plan too. (R58's) care plan says she is supposed to be supervised but she is pretty independent, so I will update it. On 6/4/2024 at 3:20 PM, V17, stated, I don't really like any one to be unsupervised, but I revised the Care Plan. On 6/6/2024 at 10:10 AM, there were two cartons of cigarettes observed on R58's bed. On 6/6/2024 at 11:03 AM, V3, Activity Director, stated R58 keeps her cigarettes and lighter in her room. R58's Care Plan, dated 6/4/2024 documents, I am alert and able to smoke independently per assessment. (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Facility's Smoking Policy and Procedure, undated, documented, Purpose: To ensure all residents are safe while smoking. It continues, Smoking materials, including electronic cigarettes must be secured at the nurses' station when not in use, unless otherwise specified. It further documents, Residents who are determined by the care plan team to be able to smoke without supervision may smoke at will in the designated smoking area. Smoking materials will be returned to the nurse's station and will not be kept in the residents room, unless a secured area or mechanism is available in the residents' room. 33112 4. On 6/6/24 at 9:47 AM, V33, CNA, brought R61 to his room. V33, locked the wheelchair and placed R61's walker in front of him. V33 told R61 to stand up. V33 placed her arm under R61's right underarm and was pulling him up to stand. V33 then with her left hand grabbed the back of his pants and pulled him up more. R61 was turned and placed in the recliner. R61 had a difficult time to stand and was once up he was very unsteady on his feet. V33 failed to use a gait belt for the transfer. On 6/6/24 at 1:50 PM, V33 was questioned as to why she did not use a gait belt while transferring R61, V33 stated, Last week his daughter helped me transfer him and she told me that he stood really well. We did not use a gait belt on him that time. R61's Face Sheet, undated, documents that R61 was admitted on [DATE] with diagnoses of Alzheimer's Disease and Dementia. R61's Minimum Data Set, dated dated [DATE], document that R61 is cognitively impaired, always incontinent of bowel and bladder is dependent on staff for toileting, dependent on staff for stand to chair transfer, and transfer to toilet. The facility policy, Gait Belt Use, dated 7/2014, documents, It is the policy of (the facility) that gait belts will be used when staff are transferring weight bearing residents or assisting them with walking for the safety of the resident or the employee.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33112 Based on interview, observation, and record review, the facility failed to provide timely and complete incontinent care for 2 of 5 residents (R61,R71) reviewed for incontinence, in the sample of 44. Findings include: 1. On 6/6/24 at 9:47 AM, V33, Certified Nurse Aide (CNA) brought R61 to his room. V33 transferred R61 from his wheelchair to his recliner. R61's back of his pants was saturated. R61 stated that his pants were wet. V33 looked and confirmed they were wet and told R61 that she would tell his aides that he needed to be changed. On 6/6/24 at 10:30 AM, V20, CNA and V33, CNA, both entered R61's room to toilet him. R61 was transferred from his recliner to the bathroom. R61's incontinent pad in the recliner is wet with urine. R61's back of pants were saturated from the knee up to the waist band. R61 was sat on the toilet. R61's pants were pulled down. R61's incontinent brief was saturated with urine. R61 was stood up. V20 CNA then took a wash cloth that was wet with peri-wash and cleansed R61's rectal area. V20 got another wash cloth with peri-wash and then cleansed the rectal area and the buttocks. V20 failed to cleanse the his thighs, upper buttocks, penis, or scrotum. A new incontinent brief and pants were placed on R61. On 6/6/24 at 10:33 AM, V20 was questioned when R61 was changed last, V20 stated, We got him up this morning so it was right around 6:00 AM because he was trying to climb out of bed. On 6/6/24 at 12:55 PM, V20 was questioned why she did not provide complete incontinent care for R61, V20 stated, I forgot to do the front. On 6/10/24 at 1:39 PM, V1, Administrator, stated that she does expect complete incontinent care to be given. R61's Face Sheet, undated, documents that R61 was admitted on [DATE] with diagnoses of Alzheimer's Disease and Dementia. R61's Minimum Data Set (MDS), dated [DATE], document that R61 is cognitively impaired, always incontinent of bowel and bladder is dependent on staff for toileting, dependent on staff for stand to chair transfer, and transfer to toilet. 2. On 6/6/24 at 9:07 AM, V7, CNA and V20, CNA, both donned gowns and gloves and entered R71's room to transfer R71 from the wheelchair to the bed. R71's incontinent brief was removed. The incontinent brief was wet with urine. R71 was positioned for comfort, covered up, and given the call light. V7 was questioned if R71 was wet, V7 stated, Yes he was. On 6/6/24 at 12:55 PM, V20 was questioned why R71 was not provided incontinent care before covering him up, V20 stated, Did we forget his front? Oh no we forgot care altogether didn't we? (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R71's Face Sheet, undated, documents that R71 was admitted on [DATE] with diagnosis of Hypertension, Type 2 Diabetes Mellitus, Unspecified Open Wound to right foot, and need for assistance. R71's MDS, dated [DATE], documents that R71 is moderately cognitively impaired, dependent on staff for toileting, and dependent on staff or requires maximum assistance from staff for all mobility. The policy, Perineal Care, dated 7/2017, documents, The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition. It continues, a. Wet washcloth and apply soap or skin cleansing agent. b. Wash perineal area starting with urethra and working outward. (Note: If the resident has an indwelling catheter, gently was the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.) (1) Retract foreskin of the uncircumcised male. (2) Wash and rinse urethral area using a circular motion. (3) Continue to wash the perineal area including the penis, scrotum, and inner thighs. Do not reuse the same washcloth or water to clean the urethra. c. Thoroughly rinse perineal area in same order, using fresh water and clean washcloth. (Note: If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.) d. Gently dry perineum following the same sequence. e. Reposition foreskin of uncircumcised male. f. Instruct or assist the resident to turn on his side with his upper leg slightly bent, if able. g. Rinse washcloth and apply soap or skin cleansing agent. h. Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks. i. Dry area thoroughly. 11. Discard disposable items into designated containers. 12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. 13. Reposition the bed covers. Make the resident comfortable.

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	145502	A. Building B. Wing	06/10/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40701 Based on interview and record review, the Facility failed to ensure physician's orders were accurately completed and implemented for 1 of 3 residents (R50) reviewed for significant medication error in the sample of 44. Findings include: R50's Face Sheet dated 6/5/2024 documents R50 has a diagnosis of Type 2 Diabetes Mellitus (DM). R50's Discharge Medication List Instructions dated 5/29/2024 documents, Insulin glargine (a medication to control blood sugar)-inject 50 units twice a day for diabetic control. R50's Physician's Order Sheet (POS) dated 12/29/2024-6/6/2024 documents Accu checks (blood glucose monitoring) before meal and at bedtime were ordered on 6/5/2024. R50's POS further documents insulin glargine 28 units was order once a day but discontinued (d/c) on 5/29/2024. It continues to document 5/29/2024-5/30/2024 (d/c date) insulin glargine 50 units twice a day. R50's POS documents insulin glargine 28 units was re-ordered on 6/5/2024. R50's Event Report dated 6/5/2024 documents, Description: Lantus (insulin glargine) not administered due to no order since hospitalization return. Description of Error- 5/29/2024-6/5/2024. It further documents the error was found on 6/5/5024 by V2, Director of Nursing (DON). It continues to document, Resident returned from hospitalization with order of Lantus 50 units BID (twice daily). Resident was on 28 units at bedtime at this facility before going to hospital. Order not clarified or inserted. No order for any Lantus in from 5/29/2024-6/5/2024. Resident did not receive any Lantus during this time. R50's Event Report dated 6/5/2024 documents R50's blood sugar was taken at 3:15 PM and was 278 (normal blood sugar is 80-120). It continues to document, Writer called (V30, R50's MD), reported to nurse of resident not receiving Lantus since returning from hospital, due to confusion on orders from hospital of Lantus 50 units BID with an original date of 2022. And nurse states re-inserted order resident was on here at facility before hospital and now not finding order. Writer clarified right dosage with (V30) of 28 units of Lantus at bedtime, which was previous order here at facility for resident and accu checks to be done ACHS (before meals and at bedtime). A1C (a laboratory test to determine long term levels of blood sugars) to be drawn tomorrow as well. Monitor and call if blood sugars are continuously increased. R50's Hemoglobin A1C dated 6/7/2024 documents R50's Hemoglobin A1C was elevated at 8.7 (normal is 4. 1-6). (continued on next page)

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	145502	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/2024, V2, Director of Nursing (DON) stated, (R50) is now accu checks before meals and at bedtime. We realized it when she came back from the hospital, she had a different order than when she was here prior. They ordered a 'big jump' on the Lantus. Nurse that was here when she came back was agency. She was questioning it. (V8, Licensed Practical Nurse). We put her back on Lantus 28 units nightly like she was on prior to going to the hospital. They sent her back on Lantus 50 units BID (twice a day) and I didn't feel comfortable with that so we said we would get it clarified the next day using our nursing judgement. Yesterday when I was looking for the accu check there wasn't even an order for Lantus. I put the order back in for the 28 units. I made the daughter aware she missed her Lantus since she came back on the 29th (5/29/2024). She does not get anything orally. I completed a medication error. Her doctor is (V30). On 6/6/2024, at 10:39 AM, V5, R50's daughter, stated, One nurse told me she (R50) wasn't getting her insulin. Her sugars are running high all the time. When she went to the hospital it was close to 300. On 6/10/2024 at 1:13 PM, V4, Assistant Director of Nursing (ADON) stated R50 is a diabetic and she would consider missing her diabetic medication for that length of time to be a significant medication error. On 6/6/62024 at 1:15 PM, V2 stated she would consider missing the insulin for 'about a week' and not being on any other medication for diabetes would be a significant medication error. V2 added that R50 could have potentially gone into DKA (Diabetic Ketoacidosis). The Facility's Policy Obtaining and Following Physician's Orders dated July 2014 documents, It is the policy of (Facility) that physician's orders will be obtained by licensed personnel and followed. If the licensed professional does not in his/her best judgement think that the order is not in the best interest of the resident, he/she has the obligation to further investigate prior to fulfilling the order. If those orders are not followed for any reason, the Physician and Director of Nursing will promptly be notified. It continues, If the licensed person obtaining the order does not agree with the order, he/she must clarify it with the physician and state why he/she thinks this order would not be in the best interest of the resident.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44556 Based on observation, interview, and record review, the facility failed to remove expired medication and glucose control solution from refrigerator and medication cart and date multi dose insulin pens after opening. This failure has the potential to affect all 69 residents residing at the facility. Findings include: 1.On 06/03/24 at 09:40 AM, during the inspection of the medication room refrigerator, it contained a vial of Tuberculosis (TB) solution observed to be open and there was no date noted on the box or the vial. V8, Licensed Practical Nurse (LPN) said the TB solution is used on everyone in the facility and the vial should be disposed of 30 days after opening. On 06/03/24 at 09:45 AM, there was a bottle of Azithromycin oral suspension 200mg (milligrams) per 5ml (milliliter) observed in the refrigerator that did not have a name or date on the bottle. The directions on the bottle states it should be destroyed after mixing use within 10 days. There was a 5ml multi dose vial of Influenza vaccine 2023-2024 opened with no open date on the bottle or box and had an expiration date of May 28th, 2024. On 06/03/24 at 09:53 AM, there was floor stock Bisacodyl medicated laxative suppositories with an expiration date of 12/2023 was observed in the refrigerator that had seven out of 12 suppositories left in the box. V8 verified they were expired. She said if there is no name on the suppositories then they are floor stock. 2.On 06/03/24 at 09:56 AM, B Hallway medication cart was inspected and contained the following: - Lantus insulin Pen for R63 with no opened date. - Lantus insulin Pen for R16 with no opened date. - Lantus insulin Pen for R43 with no opened date. On 06/03/24 at 09:56 AM, V8 verified there were no open dates on the insulin pens, and she stated they should be destroyed after 28 or 30 days. She said some are 28 days and some are 30 days. On 06/03/24 at 11:05 AM, C hallway medications cart was inspected and contained the following: - Aspirin 325 mg (milligram) enteric coated tabs with the expiration date of 4/24 were observed in the cart. - (Brand Name) Glucose control solutions were observed in the cart. The level 2 solution was observed to have an expiration date of 01/17/2023 and the level 3 solution was observed to have an expiration date of 01/18/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145502	A. Building B. Wing	06/10/2024

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Taylorville Care Center	600 South Houston Taylorville, IL 62568

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/03/24 at 11:11 AM, V9, Registered Nurse (RN) stated he isn't sure when the quality control checks are done on the glucometers, he said he just knows they aren't done on day shift. V9 verified the expiration dates on the solution bottles and box. On 06/10/24 at 11:55 AM, V1, Administrator stated she would expect the Director of Nursing (DON), or Assistant Director of Nursing (ADON) would be checking the refrigerator for anything expired, medications unlabeled, and for the resident's insulin pens to have an open date on them. On 06/10/24 at 01:10 PM, V2, Director of Nursing (DON) she would expect the nurses to put the date on the insulin pen after opening it. She said TB solution is good for 30 days after it is opened. V2 said she has been checking the medications room for expired meds and when the night nurse has time, she will do it. The facility's Storage of Medications, revision date of 05/01/2018, documents Policy Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medications supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. It further documents Expiration Dating C. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, blood sugar testing solutions and strips once opened, require an expiration date shorter than the manufacturer's expirations date to insure medication purity and potency. It also documents D. 2) Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date. Once opened, these will be good to use until the manufacturer's expiration date is reached unless the medications are: In a multi-dose injectable vial An ophthalmic medication An item for which the manufacturer has specified a usable life after opening. E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be [30] days unless the manufacturer recommends another date or regulations/guidelines require different dating. It also documents H. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner. The Long Term Care Facility Application for Medicare and Medicaid, CMS 671, dated 06/03/24, documents that the facility has 69 residents living in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44556 Based on observation, interview, and record review, the facility failed to properly store and label foods with open dates, secure hair during meal preparation and service, and utilize hand hygiene to prevent food contamination and/or borne illness. This failure has the potential to affect all 69 residents residing at the facility. Findings Include: 1.On 06/03/24 at 09:13 AM, the standup freezer was inspected and contained: - An open box of frozen pancakes with no open date and the inner bag with the pancakes in it was not sealed. - One box of maple sausage links with a date of 4/16 (arrival date) that was open, and the inner bag was not sealed in any way. There were two boxes of maple pork sausage links dated 5/14 (arrival date) in the freezer that were open and in the inner bag was not sealed or secured/tied up. On 06/03/24 at 09:20 AM, the walking refrigerator was inspected, and it contained: - A gallon of milk that was open with no open date on it. - On one of the shelves there was a bundle of celery that was not in any kind of bag or storage container and the there was an open box of lettuce, and the inner bag was not sealed. On 06/03/24 at 09:23 AM, the deep freezer in the storeroom was inspected and contained: - A large container of strawberry cheesecake ice cream that was open with no open date on it. On 06/03/24 at 09:23 AM, V10, Dietary Manager said he didn't date the ice cream when he opened it. He said came in another box that had multiple containers of ice cream in it and they just took it out. 2.On 06/03/24 at 11:50 AM, V11, Cook, had a beard. V11 was wearing a hairnet, but he did not have on a beard guard. On 06/03/24 at 11:55 AM V12, Dietary Aide had her hairnet on but did not have it covering her bangs. V13, Dietary Aide had on her hairnet, but she had hair hanging out all around her face and neck. 3.On 06/03/24 at 11:58 AM, V11, Cook washed his hands got a pair of gloves from the box but did not put them on. He proceeded to place lids on the food that was on the steam table, removed aluminum foil from food that was on the steam table and covered them with lids. He then put on the gloves he had gotten form the box a few minutes earlier and donned them. He then removed the lids covering the food, moved plates from on top of the steam table lower so he was able to reach them and began to serve the food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/03/24 at 12:09 PM, V13, Dietary Aide went into the refrigerator and retrieved a gallon of milk. V13 then got a pair of gloves out of the box and donned them with no hand hygiene done prior to putting on the gloves. V13 began to set up meal trays and liquids for the residents. On 06/03/24 at 12:11 PM V11 was observed going back to the storeroom to get a resident a bag of chips with his gloves on then came back and started serving food with the same gloves and no hand hygiene was done. On 06/03/24 at 12:17 PM, V11 walked over in the dishwashing area, touched the wall, walked around the other end of the kitchen, back over to the serving area, and then began to serve food with no hand hygiene or glove change done. On 06/03/24 at 12:18 PM, V13 was observed opening the microwave meal and putting in the microwave for a resident with her gloves on then came back over to the food prep area and with the same gloves on filled a cup with ice. Then at 12:20 PM she removed the meal from the microwave with the same gloves and placed it on a tray. At 12:21 PM, she removed her gloves, got more trays, got new gloves, and donned them without doing any type of hand hygiene. On 06/10/24 at 11:15 AM, V10 stated he would expect the kitchen staff to always have their hairnets on and it should be covering all their hair. He said he would expect anyone with a beard to have their beard covered also. V10 stated he would at the very least expect someone who was working with the food then goes to the back to get something for a resident to do hand hygiene (hand sanitizer) and change their gloves before starting to serve trays again. V10 stated he would expect an open box to be dated with the open date and the inner bag to be twisted and tied off, so the food doesn't fall on the floor. On 06/10/24 at 12:00 PM, V1, Administrator, stated she would expect the kitchen staff to have their hairnets on and if they have a beard to have it covered up with something even if it is with a facemask upside down. She would expect any open food in the freezer to have an open date on it and for the bag to be tied up and not be left open. The facility's Cleaning and Sanitation policy, revision date of January 2012, documents Policy: The kitchen will be maintained in a clean and sanitary condition. The state and/or federal food code will be maintained on file within the food service department and will be the basis of all sanitation and food safety practices. Procedure: 1. The best way to prevent contamination of food or food surfaces is to frequently wash hands. Hands should be washed before starting work, after coughing or sneezing, after handling garbage, picking up an article off the floor, after using the toilet, after smoking, after handling soap and detergents, after touching your hair or face and after all breaks. Thorough hand washing is done using soap and warm water and scrubbing hands together vigorously (20 seconds) and then rinsing them well. Dry hands with a paper towel and turn faucets off using the paper towel instead of clean hands. 2. Hairnets or hair coverings will be worn at all times. It further documents 9. Unused food will be covered, timed, labeled, and dated with their content. All potentially hazardous unused food or leftovers will be cooled following the Two-Stage Cooling Method. The Long-Term Care Facility Application for Medicare and Medicaid, CMS 671, dated 06/03/24, documents that the facility has 69 residents living in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 33112 Based on observation, interview, and record review, the facility failed to remove soiled linens to prevent cross contamination, perform hand hygiene before donning and doffing of gloves, provide a clean barrier for supplies, and keep supplies clean to prevent the spread of infection for 6 of 17 residents (R14, R26, R60, R61, R62, R71) reviewed for infection control in the sample of 44. Findings include: 1. On 6/6/24 at 9:47 AM, V33, Certified Nurse's Aide, CNA, brought R61 to his room and transferred from his wheelchair to his recliner. R61's back of his pants was saturated. R61 stated that his pants were wet. V33 looked and confirmed they were wet and told R61 that she would tell his aides that he needed to be changed. V33 failed to remove the wet soiled incontinent pad in the wheelchair. On 6/6/24 at 10:30 AM, V20, CNA, and V33 entered R61's room to toilet him. V33 put on gloves without hand hygiene. R61 was transferred from his recliner to the bathroom. R61's incontinent pad in the recliner is wet with urine. R61's back of pants were saturated from the knee up to the waist band. V20 put on gloves without hand hygiene. After completing care, R61 was transferred back to his wheelchair onto the soiled incontinent pad from earlier. The soiled incontinent pad from the recliner was never removed. On 6/10/24 at 1:39 PM, V1, Administrator, stated that she does expect the soiled linens to be changed, hand hygiene performed before putting on gloves, and after removing them. 2. On 6/6/24 at 10:00 AM, V7 CNA and V20 brought R62 to her room to toilet her. V7 and V20 donned gloves without hand hygiene before. R62 was transferred to the toilet. R62's incontinent brief was pulled down. It was dry. R62 urinated on the toilet. R62 was stood back up. V20 wiped R62 with toilet tissue and her brief and pants were pulled up. R62 was transferred back to the wheelchair and then into her recliner. V20 removed her gloves and then operated the remote control for the recliner for R62's comfort. 3. On 6/6/24 at 11:55 AM, V2, Director of Nurses, (DON) and V4, Assistant Director of Nursing, ADON, entered R71's room. Both were wearing gowns and gloves. V4 provided pressure ulcer treatments to 5 different pressure ulcers on R71. V4 placed the gauze pads, wound cleanser, and the medi-honey directly on R71's bed. V4 at one point of the treatments placed all the supplies on a soiled incontinent pad. On 6/6/24 at 4:00 PM, V1, Administrator, stated that the supplies should always be placed on a clean surface. On 6/10/24 at 10:52 AM, V4, was questioned why she did not put down a clean barrier for R71's pressure ulcer treatment supplies, V4 stated, I just took this position three weeks ago. I came from a hospital. V4 was questioned if the supplies were just for R71 or if they were put back into the treatment cart, R71 stated, They are the treatment carts supplies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy Infection Control, dated 7/2017, documents, It is the policy of (facility) to make every effort to prevent the spread of infection in the facility. It continues, 4. Staff will use proper glove and hand washing technique. 5. Staff will use proper linen handling technique. The policy Handling of Laundry and Bedding, Soiled, dated 3/24/2020, documents, 3. Deposit soiled briefs or under pads in specially designated laundry hampers or waste containers. The policy Wound Management Program, dated 2/26/21, fails to document the use of a clean surface barrier. 44556 4. On 06/04/24 at 08:16 AM, V8, Licensed Practical Nurse (LPN) did not perform any hand hygiene prior to getting R14's medications ready to give. V8 then gave R14 her medications she went back to the medications cart and no hand hygiene was done. 5. On 06/04/24 at 08:19 AM, V8, LPN did not do any type of hand hygiene prior to getting R26's medications pulled up to give. After getting the medication ready R26's was no longer in. On 06/04/24 at 08:27 AM, after giving R26 her medication V8 did not do any type of hand hygiene. 6. On 06/04/24 at 08:50 AM, V4, Assistant Director of Nursing (ADON) proceeded to take R60's blood sugar. She cleansed R60's right pointer finger with an alcohol pad, used a new lancet, stuck R60's finger, and attempted to get enough blood for the test strip. After placing the blood on the test strip, the machine then did not read the strip. V4 removed her gloves went out the med cart to get another lancet to prick R60's finger. V4 applied clean gloves without doing any hand hygiene and then pricked R60's finger again after cleansing it off. She applied blood to the test strip and the glucometer again had an error. V4 went to the medication cart again with her dirty gloves on and came back with the bottle of test strips and the same gloves on. V4 then obtained R60's blood sugar. V4 removed her gloves cleaned up the discarded lancets and test strips from R60's over the bed table, left the room, disposed of the trash, and started working on the computer with no hand hygiene observed. No hand hygiene was observed being done. On 06/10/24 at 11:55 AM, V1, Administrator said she would expect hand hygiene to be done between each resident during a medication pass. On 06/10/24 at 01:10 PM, V2, Director of Nursing (DON) stated she would expect the nurses to perform hand hygiene in-between each resident's meds (medications) and after giving medications. On 06/10/24 at 01:15 PM, V8, LPN stated hand hygiene should be done at least every third or fourth resident especially if you touch the resident you need to wash your hands. The facility's Handwashing policy, revision date of December 2020, documents Policy: It is the policy of this facility that all staff thoroughly cleanses hands with friction, soap, and water to control infection and reduce transmission of organisms. Procedure: Hands should be thoroughly washed before and after providing resident care. Proper handwashing techniques must be followed at tall times. It further documents 8. Hand antiseptic/hand sanitizer as a supplement or alternative to the use of soap and water when hands are not visible solid.