

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146048	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Taylorville Skld Nur & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to secure handrails to the wall in a safe and secure manner. This deficiency has the potential to affect all 79 residents/visitors and employees in the facility by compromising their safety when grabbing ahold of the handrails. Findings Include: On 06/01/2026 at 9:45 AM the handrail between rooms [ROOM NUMBERS] was loose and moved easily. On 06/03/2026 at 10:00 AM the handrail between rooms [ROOM NUMBERS] was loose and moved easily, at 10:03 AM the handrail outside of room eight was loose and moved easily, at 10:06 AM the handrail outside of room [ROOM NUMBER] was loose and moved easily, at 10:07 AM the handrail outside of room [ROOM NUMBER] was loose and moved easily and at 10:09 AM the handrail outside of room [ROOM NUMBER] was loose and moved easily. On 06/03/2026 at 1:55 PM V11, Maintenance Director, confirmed that the handrails were loose and easily moveable between rooms [ROOM NUMBERS], between rooms [ROOM NUMBERS], outside of room eight, outside of room [ROOM NUMBER], outside of room [ROOM NUMBER], and outside of room [ROOM NUMBER]. The Midnight Census Report provided by V1 Administrator on 6/1/26 at 9:30 AM documents 79 residents reside in the facility.		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to provide a homelike environment by failing to repair a damaged wall for five of five residents (R7, R11, R12, R17, R75) reviewed for homelike environment in the sample list of 40. Findings include: On 06/01/2026 at 09:30 AM, R75's exterior wall, lower six inches, was not painted, plaster was crumbling and missing in spots where the wall and floor intersect and there was no base board trim in place. On 06/01/2026 at 09:33 AM, R12's exterior wall, lower six inches, was not painted, plaster was crumbling and missing in spots where the wall and floor intersect and there was no base board trim in place. On 06/01/2026 at 09:35 AM, R11's exterior wall, lower six inches, was not painted, plaster was crumbling and missing in spots where the wall and floor intersect and there was no base board trim in place. On 06/01/2026 at 09:40 AM, R7's exterior wall, lower six inches, was not painted, plaster was crumbling and missing in spots where the wall and floor intersect and there was no base board trim in place. On 06/01/2026 at 09:42 AM, R17's exterior wall, lower six inches, was not painted, plaster was crumbling and missing in spots where the wall and floor intersect and there was no base board trim in place. On 06/02/2026 at 03:42 PM, R75 stated R75's room does not feel homelike because the walls are not finished and they put a board over it today trying to hide it. R75 stated it feels institutional in here. On 6/2/26 at 4:15 PM, R17 stated due to the wearing of the floor along the walls, it does not feel like home in the facility. On 06/03/2026 at 09:35 AM V11, Maintenance Director, confirmed R75, R12, R11, R7 and R17's rooms were missing the paint, the baseboard trim and the rooms had crumbling plaster exposed where the wall and the floor meet. V11 stated when the PTAC units (self-contained heating and air conditioning unit) were installed the trim had to be removed and has not been re-installed.		

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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. Based on observation and interview, the facility failed to provide adequate electrical outlets in resident rooms for three of three residents (R14, R76, R8) reviewed for accident hazards in the sample list of 40. Findings Include: On 06/03/2026 at 12:27 PM R14's room contained two power strips were being used. One power strip was plugged into a two-receptacle outlet with three devices plugged into it. The other power strip was plugged into a two-receptacle outlet with three devices plugged into it. On 06/03/2026 at 12:32 PM R76's room contained a multi-port that was plugged into a two-receptacle outlet. Two devices and one two wire extension cord were plugged into the multi-port. On 06/03/2026 at 12:32 PM R8's room contained a power strip that was plugged into a two-receptacle outlet. Two devices were plugged into the power strip. On 06/03/2026 at 11:30 AM V11, maintenance director, confirmed there were multiple rooms, including R14, R76 and R8's rooms, with multiple multi-plug power strips in use. V11 also confirmed there were multiple rooms with two wire extension cords connecting appliances to the power strip. V11 stated the facility does not have a policy with regards to power strip use.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide dignified dining services while maintaining resident's rights for three of three (R20, R35 and R50) residents reviewed for dining meal service in the sample list of 40. Findings include: 1. R20's Care Plan dated 6/3/2026 documents R20 has a diagnosis of Dementia. This Care Plan also documents an admission date of 01/03/2025. R20's Care plan dated 3/12/2026 documents to provide feeding/dining assistance as needed. R20's Care plan dated 3/12/2026 documents R2 has impaired cognitive function related to the Brief Interview for Mental Status (BIMS) score and dementia. R20's Minimum Data Set (MDS) dated [DATE] documents R20 has severe cognitive impairment. R35's Care Plan dated 6/3/2026 documents R35 has a diagnosis of Alzheimer's Disease. This Care plan also documents an admission date of 02/01/2025. R35's Care Plan dated 2/5/2026 documents R35 has impaired cognitive function/Dementia or impaired thought processes related to Alzheimer's. R35's Minimum Data Set (MDS) dated [DATE] documents R35 has severe cognitive impairment. On 6/1/2026, during a one-hour continuous dining service observation conducted from 12:00 p.m. to 1:00 p.m. R20 and R35 were sitting next to each other at a table in the middle of the dining room underneath the air conditioning unit (AC) vent that was leaking clear liquid from the condensation. Condensation continued to drip from the vent from 12:00 p.m. to 1:00 p.m. onto the table while R20 and R35 were eating their lunches. Drops of water were on the table next to R20 and R35's plates of food all throughout R20 and R35's mealtime. During this time, no staff member checked on R20 and or offered an alternative table. On 6/3/2026 at 8:40 a.m., V19 Dietary Aide stated the AC has been leaking from the condensation and no residents should sit or eat on the table directly under the leaking vent. On 6/3/2026 at 12:51 p.m. V21 Kitchen Manager stated if the AC was leaking, residents should not sit directly under the AC vent. On 6/4/2026 at 9:05 am V1 Director of Nursing (DON) stated if there was a water leak from the AC condensation and residents were seated underneath, staff members should move the residents and re-arrange the tables and then call for the housekeeping to clean the area. 2. R50's Care Plan dated 6/3/2026 documents a diagnosis of Transient Ischemic Attack (TIA) and Aphasia. This Care plan also documents an admission date of 04/30/2026. R50's Care Plan dated 5/4/2026 documents R50 has impaired communication related to a diagnosis of Sensorineural Hearing Loss. R50's Minimum Data Set (MDS) dated [DATE] documents R50 has severe cognitive impairment. On 6/2/2026 during lunch service from 12:00 p.m. to 12:35 p.m., R50 was sitting at the dining table with two other residents. The other two residents were served meal trays at 12:04, however R50 did not receive a meal tray at that time. R50 received R50's meal tray at 12:24 p.m., 20 minutes later than the other two residents sitting at the same table. The other two residents were already finished eating their lunch when R50 received R50's meal tray. On 6/2/2026 at 12:24 p.m. R50 was not interviewable. On 6/2/2027 at 12:25 p.m., V7 Certified Nurse Assistant (CNA) stated meal trays should be served per table and all residents at the table should be served at the same time. On 6/3/2026 at 8:40 a.m., V19 Dietary Aide stated kitchen staff should serve the meal trays per table and make sure all residents at the table get meal trays at the same time and don't leave anyone out. On 6/3/2026 at 12:51 p.m. V21 Kitchen Manager stated kitchen staff serve the meal trays per table. V21 stated all residents at a table should be served all at the same time. V21 stated even the residents that just rolled up were served a meal tray immediately to make sure no one was left out at the table. Facility's Meal Distribution Policy dated 9/1/2021 documents meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview and record review, the facility failed to ensure appropriate positioning during enteral feeding and failed to ensure the enteral feeding bottle was labeled with all of the required information for two of two (R1 and R85) residents reviewed for enteral feeding in the sample list of 40. Findings include: R85's Care Plan dated 6/2/2026 documents R85's diagnosis of Dysphagia. This Care Plan also documents an admission date of 5/28/2026. R85's Care Plan dated 5/29/2026 documents to administer enteral nutrition per physician orders. R85's physician's order dated 5/28/2026 documents an order for Enteral Feed every shift. Administer Jevity 1.5 via an Enteral Pump and Infuse at 45 ml/hr (milliliters/hour) X (times) 24 hrs (hours). R85's Minimum Data Set (MDS) dated [DATE] documents R85 has moderate cognitive impairment. On 6/1/2026 at 10:04 a.m., R85 was lying supine (flat) in bed with the enteral feeding attached to R85's Percutaneous Endoscopic Gastrostomy (PEG) tube and the feeding was running. Enteral feeding bottle was noted to be unlabeled at this time. On 6/3/2026 at 8:25 a.m., R85 was lying in bed supine, and enteral feeding was attached to R85's PEG tube and was running. On 6/1/2026 at 10:04 a.m., V3 Licensed Practical Nurse (LPN) confirmed tube feeding was not labeled for R85. V3 stated the tube feeding should be labeled with the resident's name, date, time, rate, route and room number. V3 confirmed R85's head of bed was supine and should be at a semi-Fowlers (elevated at 30-45 degrees) or high fowlers (elevated at 60-90 degrees). On 6/3/2026 at 8:47 a.m., V18 Licensed Practical Nurse (LPN) confirmed R85's bed was at a supine position at this time. V18 stated R85's head of bed should be elevated to at least 30 degrees to prevent aspiration. On 6/2/2026 at 11:40 a.m., V15 Assistant Director of Nursing (ADON) stated all residents enteral feeding bottles should be labeled with the resident's name, room number, date and time, route, method and rate of administration. V15 stated all residents on enteral feeding should have their head of bed elevated to at least 30 to 40 degrees at all times to prevent aspiration. 2. R1's Care Plan dated 6/2/2026 documents R1's diagnosis of Dysphagia. This Care Plan further documents an admission date of 4/23/2026. R1's Care plan dated 4/24/2026 documents R1 has an impaired gastrointestinal status related to Crohn's disease, surgery to place Percutaneous Endoscopic Gastrostomy (PEG) tube and Intestinal Obstruction. R1's physician's order dated 4/23/2026 documents an order for Enteral Feed five times a day. Administer Osmolite 1.5 via bolus 300 ml/hr. 5x daily. Total 1500 ml / 2250 total calories, total free fluid 1143 ml, per day via G tube (Gastrostomy tube). As well as 1200ml fluids from flushes for a total of 2343ml fluids/day. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively impaired. On 6/3/2026 at 9:00 a.m., V18 Licensed Practical Nurse (LPN) performed enteral feeding via syringe on R1. Enteral feeding bottle was opened and was not labeled except for a date of 6/3 at this time. On 6/3/2026 at 9:15 a.m., V18 confirmed the bottle had a label with incomplete information. V18 stated the enteral feeding bottle should have resident's name, room number, date and time, and rate of administration. Facility's Gastrostomy Policy dated 8/14/2023 documents the facility shall care for residents receiving artificial nutrition by means of gastrostomy tube, under the direction of the resident's primary physician and following nursing best standard of care. This policy documents an implementation of resident's head of bed shall be elevated at all times. Facility's Enteral Tube Feeding via Syringe (Bolus) procedure policy (undated) documents a general guideline to check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID and room number, b. type of formula, c. date and time the formula was prepared, d. route of delivery, e. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	access site, f. method (pump, gravity, syringe); and g. rate of administration milliliters per hours (ml/hour).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to place an oxygen in use warning sign at the room entrance door to three of three (R31, R58 and R85) residents reviewed for respiratory care in the sample list of 40. Findings include: 1. R31's Care Plan dated 6/3/2026 documents a diagnosis of Acute and Chronic Respiratory Failure with Hypercapnia, and Dependence on Supplemental Oxygen. This Care plan also documents an admission date of 5/21/2026. R31's Order Summary Report dated 5/21/2026 documents a physician's order for oxygen at two liters per minute via nasal cannula continuously. R31's Minimum Data Set (MDS) dated [DATE] documents R31 is cognitively intact. On 6/01/2026 8:55 a.m., R31 was lying in bed with oxygen on at two liters via nasal cannula. There was not a no smoking/oxygen in use sign at the room door at this time. On 6/1/2026 at 10:41 a.m., V4 Certified Nurse Assistant (CNA) confirmed there was no warning sign at R31's room door. V4 stated there should be a sign at the door warning R31 was on oxygen. On 6/1/2026 at 10:41 a.m., V5 Certified Nurse Assistant (CNA) confirmed there was no warning sign at R31's door. V5 stated there should be a sign at the door. 2. R58's Care Plan dated 6/3/2026 documents R58's diagnosis of Chronic Obstructive Pulmonary Disease (COPD). This Care Plan also documents an admission date of 4/03/2026. R58's Care Plan dated 2/13/2026 documents R58 has an impaired respiratory status related to COPD. R58's Order Summary Report dated 4/2/2026 documents a physician's order for oxygen at two liters per minute via nasal cannula continuously. R58's Minimum Data Set (MDS) dated [DATE] documents R58 has severe cognitive impairment. On 6/1/2026 at 9:10 a.m., R58 was sitting in a recliner in 58's room with oxygen on at two liters via nasal cannula. There was no no smoking/oxygen in use sign at the room door at this time. On 6/1/2026 at 11:07 a.m., V7 Certified Nurse Assistant (CNA) confirmed there was no warning sign at the door, V7 stated there should be a no smoking sign at the door for R58. 3. R85's Care Plan dated 6/3/2026 documents R85's diagnosis of Chronic Obstructive Pulmonary Disease (COPD). This Care Plan also documents an admission date of 5/28/2026. R85's Order Summary Report dated 5/28/2026 document for oxygen at two liters per minute via nasal cannula continuously. R85's Minimum Data Set (MDS) dated [DATE] documents R85 has moderate cognitive impairment. On 6/1/2026 at 10:04 a.m., R85 was lying in bed with oxygen on at two liters via nasal cannula. There was not a no smoking/oxygen in use sign at the room door at this time. On 6/1/2026 at 10:04 a.m., V3 Licensed Practical Nurse (LPN) confirmed there was no warning sign at the door for R85. V3 stated there should be a no smoking/oxygen in use sign at the door for all residents that are on oxygen. On 6/2/2026 at 11:40 a.m., V15 Assistant Director of Nursing (ADON) stated all residents that have oxygen in their room should have a no smoking/oxygen in use warning sign on the door. Facility's Oxygen Administration Policy dated 3/17/2022 documents oxygen therapy will be administered to the resident upon the written order of a licensed physician or may be given in an emergency life-sustaining situation without an order, until an order may be obtained by a licensed physician. This policy documents a procedure to place the Oxygen in Use sign on the outside of the room entrance door.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly store an inhaler in a safe location for one of one (R40) resident reviewed for medication storage in the sample list of 40. Findings include: R40's Care Plan dated 6/3/2026 documents R40's diagnosis of Chronic Obstructive Pulmonary Disease (COPD). This Care Plan also documents an admission date of 5/15/2026. R40's Care Plan dated 5/26/2026 documents R40 had impaired cognitive function related to Brief Interview for Mental Status (BIMS) score of (10 out of 15). R40's Minimum Data Set (MDS) dated [DATE] documents moderate cognitive impairment. R40's Order Summary Report dated 5/15/2026 documents a physician's order for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT (micrograms/actuation) (Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally one time a day related to COPD. On 6/1/2026 at 9:00 p.m., R40 was sitting on R40's recliner in the room. Trelegy Ellipta Inhalation Aerosol Powder was noted at the over the bed table next to R40. R40 stated nurses always leave it with R40 to use by R40's self. On 6/1/2026 at 2:00 p.m., V8 R40's family member was visiting with R40 at this time and confirmed the inhaler was in the room when V8 entered the room. On 6/1/2026 at 2:52 p.m., V3 Licensed Practical Nurse (LPN) stated the inhaler should not be in R40's room. V3 stated medications should be in locked storage or medication rooms. On 6/1/2026 at 2:52 p.m., V3 LPN confirmed inhaler was on R40's bedside table. V3 stated R40 does not have order for medication self-administration and the inhaler should not be at R40's bedside. On 6/4/2026 at 11:38 a.m., V2 Director of Nursing (DON) stated the medications should be in the locked storage and not at resident's room unless there were physician's orders. The Facility's Medication Storage Policy dated 8/23/2022 documents a purpose to provide guidance to facility nursing staff on the proper storage of medication. The facility stores all drugs and biologicals in a safe, secure and orderly manner and in accordance with state and federal regulations. The policy interpretation and implementation documents drugs and biological used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only people authorized to prepare and administer medications may have access to locked medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure hand hygiene was performed during incontinent cares for one (R21) of three residents reviewed for infection control in the sample list of 40. Findings include: R21's electronic medical record documents an admission date of 9/7/2024. R21's Minimum Data Set (MDS) dated [DATE] documents R21's cognitive skills for daily decision making as severely impaired. R21's MDS dated [DATE] documents R21 is always incontinent and that R21 is totally dependent on caregivers to provide toileting assistance. On 6/2/2026 at 11:45 AM, V10 (Certified Nursing Aid, CNA) entered R21's room to provide perineal care. V10 entered the room with gloves already on and brought two washcloths, a package of disposable wipes, and a disposable incontinence brief with V10 into R21's room. V10 went to the bathroom faucet and turned on the water and placed the two wash clothes in the sink under the running water. V10 then removed R21's pants and tossed them on the floor next to the bathroom door. V10 stated R21 had an incontinence episode and R21's incontinence brief and pants were wet. V10 opened a package of disposable perineal wipes. V10 unfastened R21's incontinence brief and began to wipe R21's perineal area from front to back. V10 tucked the soiled wipes into the brief and folded it downward wrapping the wipes inside. V10 used the soiled gloved hands and removed V10's glasses and set them down on R21's bed. V10 wiped V10's nose with soiled gloved hands and returned V10's glasses to V10's face. V10 removed a plastic trash bag out of V10's pants pocket and placed the soiled brief inside. V10 removed the soiled bed pad, folded it up and tucked it under V10's left arm. With the same pair of gloves on, V10 placed a new brief under R21 and fastened it closed. V10 pulled out another plastic trash bag from V10's pants pocket and placed the soiled pad in the bag, picked up the wet pants off the floor and placed them in the bag. As V10 picked up the bag with the soiled wipes, one wipe fell out onto the floor and V10 picked it up and placed it back into the bag. V10 stated they use hallway hampers and trash containers. V10 confirmed V10 threw the pants on the floor so they didn't get mixed up with the clean ones, they looked identical. V10 opened R12's door and placed the bags of trash and dirty laundry in the hallway containers. V10 removed V10's soiled gloves, without performing hand hygiene, V10 shut off the sink faucet and wrung out the washcloths then placed them on the bedside table. V10 stated the washcloths were for R21's face. V10 left the room. V10 stated V10 was unaware of the handwashing policy. On 6/2/2026 at 12:15 PM, V12 (Housekeeping Manager) stated throwing soiled linens on the floor would be breaching infection control. On 6/2/2026 at 1:40 PM, V2 (Director of Nursing, DON) stated the expectation for hand hygiene is to perform hand hygiene before and after entering a resident's room, with each glove change or when gloves are soiled, and when going from clean to dirty or dirty to clean. V2 states the expectation for soiled linens and trash is to place them into plastic bags and carry them out to the hallway bins. On 6/2/2026 at 3:20 PM, V17 (District Manager) stated housekeeping was alerted to clean R21's floor a second time for the day because there was a bag of soiled linens on the floor. V17 stated they did not clean or wipe anything else down. The facility Incontinence Care Policy dated 5/16/2022 documents to perform hand hygiene before, during and after perineal care as required to prevent cross-contamination.		