STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25 at the facility for about 2 years. E16 was observed to use Quaternary test strips and no sanitation registered on the strip. E10 then primed the machine sanitizer and proceeded to test the dish machine using the Quaternary test strip with no sanitizer registering on the strip. At 9:55AM, E10 called the dish machine company and stated the chlorine sanitizer was not registering on the test strips. E10 stated they would use paper and plastic products and sanitize the pots and pans that had not been sanitized properly and also the dishes when the machine was fixed. At 10:15AM, Surveyor tested the sanitizer using chlorine test strip and the sanitizer did not register. At 12:30PM, E1, Administrator, stated they had the dish machine company and they came out and repaired the machine. At 1:30PM, Z1, dish machine representative, stated the sanitizer squeeze valve in the pump was not working. E10 stated the machine had last been checked for sanitizer on February 1, 2012. Z1 stated he would expect the facility to check the sanitizer daily. 2. The CMS 672 Resident Census and Conditions of Residents dated 2-8-12, documented the facility had a census of 72 residents.	F 371		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210b)2) 300.1210b)4)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 26 300.1210b)5) 300.1210c) 300.1210d) 3001210d)4) 300.3240a) 300.3240b) 300.3240c) 300.3240d) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 27 resident to meet the total nursing and personal care needs of the resident. 2) All nursing personnel shall assist and encourage residents so that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. All nursing personnel shall assist and encourage residents so that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 28 4) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. (Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) Based on record review, observation and interview, the facility failed to provide safe transfer(s), implement fall intervention(s) and assess, analyze the circumstances of falls and/or documented history , re-evaluate for the effectiveness of interventions and supervise risks	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 29	F9999		

to minimize the risk for recurring falls and serious injury for 3 of 8 residents (R1, R3, R10) reviewed for falls and transfers. This failure resulted in R1 sustaining a fractured leg during unsupervised toileting. This failure also resulted in R3 incurring a right hip and humerus fracture after unsupervised ambulation. R3 incurred a left hip fracture.

Findings include:

1. R3's Minimum Data Set (MDS), dated 10-6-11, documented an admission date of 9-29-11, severe cognitive impairment, extensive assistance of one person with bed mobility, transfer, walking, locomotion and toileting and unsteady balance with walking and transitions.

R3's Nursing Notes, dated 9-29-11, documented R3 was alert to person and alarms were placed on her wheel chair and bed. It was also noted R3 was up numerous times without assistance, would unclip her wheel chair alarm and not use her call light. R3's Nursing Notes, dated 10-1-11, 10-2-11, 10-3-11, 10-4-11, 10-8-11, 10-9-11 and 10-12-11 documented, in part, R3's repeated attempts of self ambulation and toileting, wandering, removing her alarm(s) and alarm(s) sounding before staff intervened. R3's Nursing Notes, dated 10-7-11 and 10-12-11 to 11-4-11, documented R3's repeated attempts of self ambulation, wandering, confusion and/or restlessness.

R3's Verification of Incident Investigation/ Administrative Summary, dated 11-4-11, documented R3 fell and fractured her right hip and right humerus when she walked unassisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 30	F9999		

down a hallway.

R3's Verification of Incident Investigation/Administrative Summary, dated 11-19-11, documented R3 was found sitting on the floor beside her bed.

R3's Verification of Incident Investigation/Administrative Summary, dated 11-25-11, documented R3 removed her alarm, fell during self ambulation and fractured her left hip. It was also noted "non-compliant with care, removes alarms, agitated, restless at most times unaware of safety measures or personal limitations." R3's Verification of Incident Investigation/Administrative Summary, dated 12-22-11, documented R3 incurred a right cheek skin tear after removing her alarm and falling from bed. It was also documented "NO sense of safety measures."

R3's chart did not document the facility's assessment, analysis of the circumstances of her falls and/or her documented repeated alarm removals and sounding alarms with attempted self-ambulation/toileting and re-evaluate the effectiveness of R3's alarms

The facility's Falls Management policy and procedure, dated 10-10, documented, in part, "Purpose. To evaluate risk factors and provide interventions to minimize risk, injury and occurrences. Fall Prevention Procedure. 1. Evaluate risk factors for sustaining falls upon admission, with comprehensive assessments, and while conducting interdisciplinary care plan reviews. 2. Initiate a fall prevention care plan when appropriate with strategies to minimize risk and potential for injuries. 3. Regularly review, revise, and evaluate care plan effectiveness at minimizing falls and injuries."

During observation of R3's transfer, on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 31	F9999		

2-8-11 at 11:35a.m., E15, Certified Nursing Assistant (CNA), and E6 (CNA), placed belt transfer device around R3's waist and transferred her from bed to wheel chair. R3 was not fully awake during the transfer and R3 did not completely bear weight as E15 and E6 slid R3 backwards while supporting her weight with the belt and holding her underneath her arms until R3 reached her wheel chair. E16 and E6 did not support her lower extremities.

2. R10's MDS, dated 12-14-11, documented severe cognitive impairment, total dependence of two plus persons physical assistance with mobility and locomotion and extensive assistance of two plus persons physical assistance with transfer. It was also noted functional limitation in range of motion for bilateral upper and lower extremities and only able to stabilize with human assistance during transfers. R10's Care Plan, dated 12-27-11, documented "transfer with assist of two and padded gait belt."

During observation of R10's care, on 2-8-12 at 1:00p.m., E8 (CNA) and E15 (CNA) raised R10's bed and provided incontinent care. After redressing R10, E8 and E15 placed a transfer belt around R10 and transferred R10 from bed to chair without lowering R10's bed. R10's feet did not touch the floor. E8 and E15 supported R10's full body weight by holding underneath her arms and with the transfer belt.

The facility's Transfer Activities procedure dated 2006, documented "Purpose. To transfer the resident from bed to chair, toilet or tub safely. 15. Depending on the amount of assistance required, the nurse may either support the resident on his/her affected side or stand in front of the resident. Support may be provided by use

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 32	F9999		

of a transfer belt. Do not support the resident under the arms as this prevents the resident from using his/her unaffected extremity."

The MDS dated 10/11/11 identifies R1 to have short/long term memory loss with severe cognitive impairment. The MDS documents that she requires extensive assist of one staff for bed mobility and extensive assist of 2 staff for transfers. The care plan dated 12/27/11 identifies R1 to be at risk for falls due to history, poor safety awareness, decreased cognition, poor balance and non-compliant with transfers and call light usage. Interventions dated 8/24/10 include call light in reach when in room, proper non skid-footwear at all times, sensor alarm in w/c (wheelchair) and recliner, check environment daily to ensure placement and functioning of w/c alarm among others. The care plan identifies two falls for R1 - 5/13/11 and 10/17/11.

The Verification of Incident Investigation/Administrative Summary dated 5/16/11 indicates R1 "fell out of w/c (wheelchair) onto ground while being transported by CNA across sidewalk. W/c struck bump in walk + fell from w/c." The report continues that R1 was transported to the emergency room via ambulance for repair of lacerations sustained in the fall. The Description of the Occurrence section indicates R1 was outside of the building in the courtyard just prior to the fall. According to the followup actions taken section, staff were inserviced regarding proper transport techniques and areas of the sidewalk were closed pending repairs.

On 2/10/12 at 11:45am, E1 Adminstrator stated everyone was outside for an event when R1 fell. E1 stated the side walk was cracked and the wheelchair tipped sideways causing R1 to fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146048	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR SKILLED NURSING & REHAB	800 MCADAM DR TAYLORVILLE, IL 62568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 33 forward out of the wheelchair. According to the Verification of Incident Investigation/Administrative Summary dated 10/27/11 description of Occurrence documents "Alarm sounding - resident in bathroom- while calling for additional help resident attempted to walk back to chair + fell." Xray showed positive for a fractured arm. The summary of the investigation documents that the Administrator stated she heard alarm sounding + upon entering room noted res (resident) on toilet. Admin (Administrator) shut off alarm + attempted to get help. Res transferred self from toilet + resulted in fall in room. Res c/o (complained of) L (left) arm pain. Orders received for X-ray in house. X-ray revealed fx (fractured) L shoulder." On 2/10/12 at 10:50am, E1, Administrator stated she heard R1's alarm sounding and when she entered her room, her wheelchair/alarm was at bedside and R1 was on the toilet in the bathroom. She said she "told her to stay there." and left the room to go get help. E1 stated when she reentered the room, R1 was on the floor. Followup actions include toileting resident before/after meals, transfers status changed to full body left with 2 assists, move room closer to nurses station, and re-educate admin. importance of usage. (B)	F9999		