STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012280	A. BUILDING: _____ B. WING _____	C 07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTHAGE TERRACE	1205 NORTH CENTER STREET CARTHAGE, IL 62321

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Z 000	COMMENTS FRI OF 2/24/23/ IL160988	Z 000		
Z9999	FINDINGS Statement of Licensure Violations (1 of 2) 350.620a) 350.1210a) 350.1210b)2) 350.1210b)5) 350.1230d)1)2) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.1210 Health Services a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or resident's 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, mental health, psychosocial, and habilitation needs that are identified in the resident's comprehensive assessment that allows the resident to attain or maintain the highest practicable level of independent functioning and	Z9999	**Attachment A** **Statement of Licensure Violations**	

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Z9999	Continued From page 1 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 resident's representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: 2) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse. 5) Other professional consulting services as identified in the comprehensive functional assessment including, but not limited to, psychiatry and other services as specified in the individual program plan. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. These requirements were not met as evidenced by:	Z9999		

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Z9999	Continued From page 2 Based on observation, record review and interview, the facility failed to develop a behavior management program including interventions to keep 1of 1 individual in the sample of 4 (R3) safe when intentionally sliding out of wheelchair during inappropriate behaviors. Findings include: ISP/Individual Service Plan identifies R3 as a non-ambulatory individual with diagnoses including Cerebral Palsy, Autism Spectrum Disorder and Seizure Disorder who functions at the Profound level of Intellectual Disability. R3's ISP documents the following, "Important Behavioral Health Information: I (R3) am currently on a behavior program for property destruction. I (R3) have also been urinating on my clothing and this is being addressed in my behavior program as well. I (R3) will get on the floor abruptly when I am upset and may initially refuse to get up but only for 1-2 minutes. I (R3) am easily redirected. No programming is needed for this behavior." R3's hospital records include the following emergency room visits: 11/7/22-Reason for visit: Fall. Diagnosis: Laceration of scalp. Done today: Laceration repair: Staples. 12/15/22-Reason for visit: Head laceration. Diagnosis: Laceration of right orbit-stitches. 12/20/22- Impression: Laceration of Scalp without foreign body. Repair method: Tissue adhesive. 12/26/22-Reason for visit: Fall. Laceration. Diagnosis: Forehead laceration-stitches. 4/26/23- Chief complaint: Fall -Patient arrived by care home staff following a fall from dining room	Z9999		

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Z9999	Continued From page 3 chair and hit the left side of head and an abrasion on left arm-Contusion of scalp. 5/7/23- Reason for visit: Fall. Diagnosis: Facial Laceration-Adhesives. 5/18/23-Reason for visit: Laceration. Diagnosis: Laceration of forehead. Done today: Laceration repair-stitches. 7/3/23-Reason for visit: Head laceration. Diagnosis: Laceration of right orbit: Done today: Laceration repair: stitches. R3's Progress Notes document the following: 11/7/22-(R3) was sitting in the wheelchair and leaned forward and fell out of the chair. (R3) hit the top of head on floor. 11/12/22-(R3) slid himself out of the wheelchair. 11/27/22-(R3) is falling out of wheelchair constantly. (R3) sits near the edge and leans over. (R3) throws himself on left side, scoots down onto the pedals and flips wheelchair up. 12/3/22-(R3) scooted self out of wheelchair to the dining room floor. 12/15/22- (R3) found on floor with a gushing head wound. 12/19/22-(R3) was in chair in the dining room and started to yell then threw self on the floor. 12/20/22-(R3) had pushed self forward in wheelchair, tipping it. (R3) fell out and hit head on medication room door. Head wound left upper forehead about the length of a quarter. 12/23/22-(R3) was on floor and was bleeding a lot from old injury on the left side of head near hair line. 12/26/22- (R3) fell forward out of wheelchair and was bleeding really bad. 4/26/23-(R3) used legs and flipped chair. When falling hit the left side of head on the outlet cover on the bottom part of wall. 7/1/23-(R3) was on floor in dining room, sat up and fell back and bit lip.	Z9999		

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Z9999	Continued From page 4 On 7/21/23 at 3:00 PM, R3 observed on the floor in bathroom and hallway, out of wheelchair, there is scarring above right eye, on forehead and on top of head. R3's ISP contained no added interventions or implementation of safety measures following the incidents which resulted in injury. 7/21/23 at 10:20 AM, E5/DSP (Direct Support Person) stated, "Usually things(injuries) happen on second shift. (R3) gets mad and throws himself out of chair." E5 stated staff is to document when injuries occurred but was not able to identify interventions to prevent harm. 7/21/23 at 12:42 PM, E7/DSP stated, "(R3) sometimes leans too far out of wheelchair and it flips. Often (R3) just upset and throws himself out." E7 was unaware of a behavior plan and states staff just try to keep (R3) calm to keep him from throwing himself out. 7/21/23 at 1:15 PM, E2/Regional Trainer and Acting QIDP (Qualified Intellectual Disability Professional) confirmed R3's Behavior Management Plan had not been changed to incorporate inventions to prevent R3 from intentionally sliding from wheelchair causing injury. 7/21/23 at 2:50 PM, E1/Administrator confirmed there should have been changes made to R3's behavior plan. (B) Statement of Licensure Violations (2 of 2) 350.620a) 350.700a) 350.1210a) 350.1210b)2)	Z9999		

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Z9999	Continued From page 5 350.1210b)5) 350.1230d)1)2) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.700 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident Section 350.1210 Health Services a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or resident's 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, mental health, psychosocial, and habilitation needs that are identified in the resident's comprehensive assessment that allows the resident to attain or maintain the highest	Z9999		

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Z9999	Continued From page 6 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 resident's representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: 2) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse. 5) Other professional consulting services as identified in the comprehensive functional assessment including, but not limited to, psychiatry and other services as specified in the individual program plan. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. 2) Basic skills required to meet the health needs and problems of the residents. These requirements were not met as evidenced by:	Z9999		

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Z9999	Continued From page 7 Based on observation, record review and interview, nursing services failed to: Complete a fall risk assessment when there was a known history of falls, Develop a care plan to include preventative measures and Ensure direct care staff were educated in the use of a mechanical sit to stand lift. These failures resulted in 1 of 1 individual in the sample (R4) falling from the mechanical sit to stand on 7/15/23 sustaining a right humerus fracture and right shoulder dislocation requiring surgical intervention. This has the potential to impact the other 13 individuals residing in the facility (R1-R3, R5-R14). Findings include: On 7/21/23 at 9:45 AM, a mechanical sit to stand lift was in the bedroom next to R4's bed. On 7/21/23 at 3:00 PM, R4 arrived at the facility. R4 had surgical dressing on right shoulder, an immobilizer on right arm and was seated in a wheelchair. Also visible is a healed scar on R4's right outer leg from previous surgery. Resident Roster provided on 7/21/23 identifies 14 individuals residing in the facility (R1-R14). ISP dated 3/31/23 identify R4 as an individual with diagnoses including Obesity, Tremors and Seizure disorder who functions at the Moderate Level of Intellectual Disability. R4's ISP documents R4 requires complete assistance with bathing, transfers and health care needs. The ISP does not identify the need for a mechanical sit to stand for transfers. R4's ISP does not contain a care plan related to falls. R4's Individual Risk Assessment Tool dated	Z9999		

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Z9999	Continued From page 8 3/20/23 is marked No in the section: Mobility/gait issues and/or history of falls/fractures and is marked Yes in the section: Adaptive Equipment: wheelchair, hi low bed and sit to stand. The facility was unable to provide a fall risk assessment completed for R4. The facility was unable to provide evidence direct care staff were trained in the use of mechanical sit to stand. 6/11/22 Reportable incident-R4 fell during shower resulting in fracture to right femur which required surgery to repair. 7/17/23 Reportable incident-R4 fell while staff was using a mechanical sit to stand transferring from bed to wheelchair-sustaining a fractured shoulder. R4's Hospital Records from 7/16/23 to 7/21/23 document, "Admitted for fall with acute displaced right proximal humerus fracture with dislocation-underwent right proximal humerus hemiarthroplasty on 7/17/23." On 7/21/23, E2/Regional Trainer and Acting QIDP (Qualified Intellectual Disability Professional) stated, "(R4) returned to the facility in March 2023 from nursing home after a fall with fractured femur. (R4) came back using the sit to stand." E2 confirmed the facility could not provide evidence of staff being trained on the use of the lift (sit to stand). On 7/21/23, E1/Administrator confirmed a nursing care plan to prevent falls should have been developed for R4. On 7/21/22, E5/DSP (Direct Support Person) stated, (R4) is the only one here that uses it (mechanical sit to stand lift)." E5 also stated, "No	Z9999		

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Z9999	Continued From page 9 training on sit to stand lift." On 7/21/23, E7/DSP (Direct Support Person) confirmed R4 required the use of a mechanical sit to stand lift for transfers. E7 stated, " I have not been trained how to use the sit to stand. Was told (by E4/former Registered Nurse Trainer) another DSP would train me." On 7/24/23, E3/RNT (Registered Nurse Trainer) stated, "I was not aware a mechanical sit to stand lift was being used to transfer (R4). (I have) Never provided training (to staff) related to sit to stand lift." E3 also stated a fall risk assessment is not part of the annual assessment and there are no papers (forms) to do for a fall risk assessment. E3 stated she had never completed a nursing assessment for R4 and was unaware R4 had a previous fall which required surgery to repair. E3 confirmed she was not aware if R4 had a care plan related to mobility/falls but stated anybody with fall history should have one. (A)	Z9999		