Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009336	A. BUILDING: ______ B. WING ______	C 03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLINVILLE REHAB & HCC	751 NORTH OAK STREET CARLINVILLE, IL 62626

(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) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of 2/10/23/IL156982	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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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 resident to meet the total nursing and personal care needs of the resident.

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:

6) 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.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and

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modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements were Not Met as evidenced by:

Based on observation, interview and record review, the facility failed to use the appropriate sling during a full mechanical lift transfer and failed to implement fall interventions in 3 of 4 residents (R1, R2, R3), reviewed for falls in the sample of 4. This failure resulted in R2 sustaining a left humerus fracture.

Findings include:

1. R2's Face Sheet, undated, documents R2 has diagnoses of Unsteadiness on Feet, Muscle Weakness and Muscle Wasting and Atrophy.

R2's Minimum Data Set (MDS), dated 12/8/22, documents R2 has moderate cognitive impairment and is dependent with 2 staff for transfers.

R2's Care Plan, dated 12/29/21, documents R2 is at risk for falls with an intervention, dated 2/10/23, to provide education to staff on full mechanical lift transfers and R2 has an Activities of Daily Living, (ADL) self-care deficit with an intervention for use of a full mechanical lift and assistance of two staff for transfers.

R2's Fall Risk Assessment, dated 7/27/22, documents R2 is at risk for falls.

R2's Progress notes document the following: 2/10/2023 at 8:05 AM, staff came and got nurse,

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said resident was on the floor. Resident was lying on the floor on his left side, states he hit his head. When assessing resident, he said his neck and left arm hurt; 2/10/2023 at 12:40 PM, resident arrived back to facility per stretcher; left arm in sling due to left humerus fracture; 2/10/2023 at 3:15 PM, fall huddle with staff, immediate intervention was training with all staff.

R2's "SBAR" assessment, dated 2/10/23, documents R2 sustained a fall related to a full mechanical lift transfer. Lift sling slipped of lift and resident fell to the ground.

The facility's final report to the Illinois Department of Public Health (IDPH), dated 2/10/23, documents on 2/10/23 at approximately 7:45 AM, R2 was being transferred when the full mechanical lift sling slipped, causing him to fall. He was sent to the emergency room (ER) and was noted to have a left humerus fracture. He was transferred to the orthopedic doctor and had a hinged elbow brace to left upper arm, locked at 90 degrees, with sleeve placed under to prevent irritation, keep arm elevated to prevent swelling and therapy to work with him on left wrist and fingers for range of motion (ROM) to prevent stiffness. He will follow up with Orthopedics in 1 week. Pain medication was ordered, and staff continue to monitor his pain and give medications as needed. Care plan was reviewed and updated as needed.

The facility's investigation into R2's fall documents the following: Occurrence Report: 2/10/23 at 7:45 AM - Nurse was called to resident's room, he was found lying on the floor on the left side, top half of sling was not connected to full mechanical lift, resident started complaining of neck pain and left arm pain,

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S9999	Continued From page 4 neuro's were initiated and within normal limits (WNL), fell out of full mechanical lift sling, complained of left arm and neck pain. 2/10/23 - Interview with V11, Past Certified Nursing Assistant (CNA) - resident slipped from full mechanical lift sling and she got help immediately and the nurse assessed resident. V11 put the sling under R2, hooked the sling to the full mechanical lift, hollered for V15 (Agency Certified Nursing Assistant/ Agency CNA) to come, V11 moved the full mechanical lift, and the sling came off the lift cross bar on the left side and R2 fell out of the left side of the sling. On 2/28/23 at 9 AM, R2 was observed with a sling and cast in place to the left arm. R2 stated they were using the lift to put him in bed, he ended up on the floor and isn't sure why. R2 stated he broke his arm but did not have to have surgery. On 2/28/23 at 8:20 AM, V5 (Maintenance Director) stated he checks the mechanical lifts weekly and anytime the staff reports a problem with them to him. V5 stated the lift that was used on R2 when R2 fell was a brand-new lift. V5 stated he checked it out and there were no mechanical issues identified. V5 stated it has been taken out of service and is in the garage. V5 stated that the staff were not using the right slings for that lift, so they have ordered new slings for it. V5 stated staff were in-serviced after the incident on appropriate use of the lifts and slings. On 2/28/23 at 9:30 AM, V2 (Director of Nursing/DON) stated V11 (Past CNA) and an Agency CNA (unsure of name, she was later identified as V15, Agency CNA) were the CNAs present when R2 fell from the lift. V2 stated there was a problem with the sling but she isn't sure	S9999		

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what it was.

On 2/28/23 at 1:30 PM, V10 (Agency Licensed Practical Nurse/LPN), stated she was passing medications in the dining room when the CNA (unsure of name), told her she needed help, R2 was on the floor. V10 stated when she entered the room, the sling was unattached to the top portion of the lift. States after the fall, they tested the sling with weight and each time the sling popped off of the ring that the sling attached to the lift with and the lift went sideways, "the lift was dangerous, there was no safety mechanism in place if the lift shifted." V10 stated the facility had just gotten the lift and is unsure if had been used prior to R2's fall. V10 stated immediately after R2's fall, the lift was taken out of service because it needed special slings. V5 stated she is unsure if the CNAs or the facility knew that prior to R2's fall.

On 2/28/23 at 2:55 PM, V5 (Maintenance Director) stated that he did not check to ensure the slings were compatible with the lift that was being used on R2 prior to it being put into use. V5 stated he put the lift together and made sure it worked, "it went up and down and was working" so he put it out on the floor for the staff to use.

On 3/1/23 at 10 AM, V4 (LPN/MDS) the slings that they have were not compatible with the lift used during R2's transfer. V4 stated it was put out for use on 2/10/23, the day of R2's fall, and was taken out of service and placed in the garage immediately after R2's fall. V4 stated that the correct slings have been ordered, and prior to putting the lift back in the facility for use, V5 (Maintenance Director) will check the lift to ensure it is operating properly. They will also check the new slings to ensure they are safe for

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use prior to using them on residents. V4 stated she will also in-service all nursing staff on the new lift and slings prior to use. V5 stated the lift slings have also been color coded so it is easy to identify what type of sling it is and who it can be used on.

The " (Brand) Battery Operated Patient Lift Owner's Manual", lift used during R2's transfer, undated, documents the following: page 3: "Warning, (Brand) slings are specially designed for use on (Brand) Lift equipment. For optimum performance use only genuine (Brand) 6-point slings on (Brand) Lift equipment. Use of non-(Brand name) slings is unsafe and may result in injury to the resident or caregiver." Page 8: "Do not use a sling unless it is recommended for use with the lift."

The Full Mechanical Lift Skills Checklist, undated, documents to gather the equipment, 2 staff must always assist with full mechanical lift transfers, place sling under resident and around the legs, position left near the resident and lower the four-point tilting frame making sure the resident's arms, legs and body are clear of the lift and frame, connect upper clips/loops to tilting frame, the connect lower clips/loops, make base of frame as wide as possible and slowly lift resident while applying pressure to tilting frame to keep it upright. Move lift to transport patient to new surface, making sure all body parts are clear of lift and frame, slowly lower the lift to position on new surface.

2. R1's Face Sheet, undated, documents R1 has diagnoses of Repeated Falls and Dementia.

R1's MDS, dated 2/21/23, documents R1 has severe cognitive impairment, requires an

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S9999	Continued From page 7 assistance of 2 staff with transfers and has a history of falls. R1's Care Plan, dated 1/4/23, documents R1 is at risk for falls with the following interventions: 1/9/23 - toilet before and after meals, gripper strips on floor beside bed, 1/10/23 - Gripper socks on when in bed, 1/11/23 - Call light in reach, 1/12/23 - "Call don't fall" sign in room, therapy to do recliner evaluation. R1's care plan goes on to document R1 has an ADL self-care performance deficit and requires an assist of 2 staff and a full mechanical lift. R1's Fall Risk Assessment, dated 1/4/23, documents R1 is at high risk for falls. R1's Progress Notes document the following: 1/4/2023 at 4:04 PM, resident found on floor of room by CNA; this nurse and registered nurse (RN) assessed resident; no injuries to legs or arms; resident complained of pain to mid-back as well as the back of head; will not allow for staff to move her; made resident comfortable; contacted physician, emergency contact, 911, and hospital. 1/4/2023 10:51 PM, writer was alerted to resident's room at 10:25 PM by resident yelling out "Help" "Help". Writer entered resident's room and found resident lying flat on her back facing her bed, with body/legs extended in front of her in alignment. It appeared to writer that resident was returning from the bathroom trying to walk towards her bed and fell. There were no witnesses to the fall. Resident was alert and oriented x 2, no complaints of pain or discomfort, no bruising or swelling noted to her head, contusions were noted to bilateral lower extremities (BLE) in various states of healing from previous falls. While assessing resident, writer noted that the resident had drawn both BLE	S9999		

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S9999	Continued From page 8 into 90-degree angles with feet flat on the floor and did not complain of any pain or discomfort. Resident was able to move all extremities x 4, grip strength was equal. With the assistance of CNAs and the use of a gait belt, resident was assisted to a standing position and then transferred to bed. Resident requested the use of a bed pan. At this time, while the CNA was placing the bed pan under resident, she complained of both right and left hip pain. Writer called appropriate personal and discussed residents' condition, and due to complaints of pain after the fall, writer was instructed to send resident to ER for further evaluation. At 10:27 PM, writer called 911. At 10:45 PM, resident left facility via stretcher, 1/5/2023 at 12:10 AM, Writer spoke with V17 (R1's Granddaughter), V17 voiced her concerns regarding the frequent falls. She stated that she would like her grandmother to have an alarm on her bed as well as in a chair, also to have side rails placed on both sides of the bed. Writer stated that her concerns would be given to the appropriate personal. 1/5/2023 1:21 AM, resident returned to facility with Impression" Recurrent falls." Discharge instructions given to resident for contusions and fall prevention, follow up with provider within 2 days. Resident is currently resting in bed; at this time, she is not voicing any signs of pain or discomfort and has fluids and call light within reach. 1/9/2023 9:08 AM, patient was found sitting on the floor in her room. R1 stated she had slid out of her recliner while trying to get up to use the restroom. Skin tear noted to right forearm. No other injuries noted. No complaints of pain or discomfort. Neuro checks initiated. Power of Attorney (POA) and Physician notified. 1/10/2023 4:12 AM, at approximately 4:00 AM, a staff LPN, while making rounds, found resident sitting on her buttocks on the floor directly in front of the recliner. Resident	S9999		

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S9999	Continued From page 9 had her legs extended forward. Resident did not have any clothing on and was barefoot. Writer noted a slightly wet (Brand) absorbent, disposable underwear on was tossed aside by the bathroom door. Writer assessed resident, resident was able to move all extremities x 4 without pain or discomfort. No apparent injuries were noted. Resident denied pain and denied hitting her head. Resident has equal grip strength and was alert and oriented x 2. When questioned where she was trying to go, R1 stated, "I was trying to get to the bathroom." Writer with the assistance of CNA and the use of a gait belt, assisted resident to a standing position and transferred to wheelchair and into the bathroom to toilet per resident's request. Fall huddle was conducted with staff with the intervention of frequent visual checks. Resident's physician was notified as well as V17. At this time, resident is resting in the recliner with fluids and call light within reach. Vital signs and neuro checks will continue for the next 72 hours per facility policy. 1/11/2023 2:14 AM, at 2:00 AM, staff was alerted to resident's room by a loud sound. Writer entered room and found resident lying on her left side near the foot of her bed. Her head was not touching the floor. Resident denies hitting her head. Resident is able to move all extremities x 4 without pain or discomfort. When writer asked about the fall, resident stated "I was going to the bathroom." Room was adequately lit, and no obstacles were on the floor. Residents incontinent brief was wet. Writer and staff CNA, with the use of a gait belt, placed resident in a standing position and then placed her in wheelchair. Resident requested to use the bathroom. Resident did void at this time. Resident was then assisted back to bed. V17 was notified of fall as well as her physician. Vital signs stable at this time, and neuro check are WNL. Fall huddle	S9999		

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S9999	Continued From page 10 conducted with staff. At this time, the resident is resting in bed with fluids and call light within reach. Vital signs and neuro checks are to continue for the next 72 hours per facility protocol. R1's "SBAR" assessment, dated 2/26/23 documents R1 was found lying in the floor beside bed. Range of motion was performed with pain to back. Unable to move resident without crying out in pain. Resident said that she did hit her head. On 2/28/23 at 10:35 AM, R1 was observed in her room in a reclining wheelchair with the feet elevated. Full body mechanical lift sling was under the resident, no rips/tears noted. R1's call light was not within reach, there was not a "Call don't fall" sign in the room and no gripper strips were beside the bed. 3. R3's Face Sheet, undated, documents R3 has diagnoses of Parkinson's Disease, Abnormalities of Gait and Mobility, Dementia, Unsteadiness on Feet and Muscle Weakness. R3's MDS, dated 9/23/22, documents R3 has severe cognitive impairment, requires a limited assistance of 2 staff with transfers and has a history of falls. R3's Care Plan, dated 2/10/17, documents R3 is at risk for falls related to Parkinson's Disease with Dementia, personal choice is to remain as independent in all ADLs despite poor safety choices and history of falls with need for monitoring. The care plan lists the following interventions: 10/30/22 - ensure he is not left unattended in the dining room; 12/21/19 - call light within reach; 2/28/23 - do not lock wheelchair when at dining room table; 12/31/19 - Non-skid	S9999		

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S9999	Continued From page 11 material in wheelchair to prevent sliding; 12/28/22 - Education done with staff on fall interventions; 12/29/22 - Ensure he has a soda with every meal; 12/25/22 - Ensure resident is one of the first to be taken out of the dining room; 1/8/23 - Frequent monitoring to assure proper positioning while in bed; 1/6/23 - gripper socks; 2/20/23 - Remove mat from floor and place wheelchair next to his bed; 12/22/22 - low bed; 6/1/22 - scoop mattress to bed; 4/22/22 - place non-skid strips in front of closet and wear non-skid socks to bed; 1/26/23 - Staff educated to ensure they are doing rounds and offering toileting every 2 hours. There were no interventions listed on the care plan for the falls on 12/5/22, 12/6/22, 12/22/22, 1/17/23, 2/9/23, 2/10/23 and 2/16/23. R3's Fall Risk Assessment, dated 11/1/22, documents R3 is at high risk for falls. R3's Progress Notes document the following: 12/5/2022 8:32 PM, resident had been sitting near nurse's station and another resident hollered that resident was on floor; this nurse assessed resident and no apparent injuries were found; CNAs assisted resident from floor and neuros were started; POA and doctor notified. 12/6/2022 11:28 AM, this nurse entered resident's room with another nurse and resident was leaning out of bed; this nurse and other nurse assisted resident back into bed and assessed for injuries; no injuries found; neuros started; notified POA and doctor. 12/22/2022 5:36 PM, this nurse was heading back to nurse's station and was notified by another nurse and CNA that resident was on floor in another resident's room; when this nurse went to assess and assisted resident up, it was noticed that resident's right shoulder appeared to be protruding out and swollen; resident was very tender in response to any touch in that area; this	S9999		

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S9999	Continued From page 12 nurse contacted Administrator and contacted on-call doctor for an order to send resident to ER for evaluation and treatment. 12/22/2022 10:30 PM, resident returned to facility from ER visit. Impression: Contusion of right shoulder initial encounter, contusion of right hip initial encounter, and right rib contusion. At this time, the resident is not voicing any complaints of pain or discomfort. Resident is resting in bed with fluids and call light within reach. 12/25/2022 9:40 PM, writer requested into dining room at roughly 8:35 PM on 12/25/2022. Resident observed sitting on his buttock with bilateral arms resting at each side, bilateral legs straight out in proper alignment. Environment was well lit, quiet and floor dry. Writer approached resident and began assessment. Fall huddle initiated. Neuro checks initiated. Resident placed in a standing position without difficulty, assisted into wheelchair and taken to his room. Physician notified at roughly 8:50 PM. POA notified at 8:54 AM. Currently resting in bed, with call light/fluids within reach. Vitals continue to be obtained/charted under neuro assessment. 12/25/2022 10:16 PM, when writer spoke with resident regarding what he was doing at the time of the fall, stated he was getting up to go to his room. 1/6/2023 6:48 PM, approximately 4:10 PM, resident found by housekeeping manager sitting on the floor. Resident fully dressed in socks only and no shoes on. Resident sitting on the floor facing the door beside roommate's bed. Resident denied pain and denied hitting head. R3 said he was trying to get roommates side table to use. Resident able to perform active range of motion with no pain. Able to come to a standing position with writer. Resident's skin assessed with no new areas. POA called and message left. MD made aware at 4:36 PM. 1/8/2023 12:17 AM, at roughly 9:40 PM on 1/7/2023 writer was requested into	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009336	A. BUILDING: ______ B. WING ______	C 03/01/2023

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S9999	Continued From page 13 resident's room. Writer approached room and observed resident sitting on the floor mat, next to his bed, with bilateral legs straight out in proper alignment, right hand holding onto bed rail and left arm resting next to left side. Environment was dark, floor dry with call light within reach. Resident was wearing gripper socks. During assessment, resident was asked what had happened during the time of the fall, stated to writer he was "trying to roll over". Fall huddle initiated, fall witnessed by additional staff. MD notified at 10:00 PM. POA called with message left at 10:22 PM. Call back received from POA at 10: 56 PM, aware of situation/agrees with steps being taken. Fall intervention in place. Call light/additional materials within reach of resident. 1/17/2023 9:20 AM, resident was found on floor laying in wheelchair in dining room; assessment was done and no complaints of pain or injury; staff assisted resident and wheelchair to upright position; neuro checks started, physician and POA notified. 1/25/2023 4:49 PM, CNA approached this nurse and advised resident was on the floor of his room; upon arrival in his room, this nurse found resident on floor between his bed and wheelchair; resident had no complaints of pain or discomfort; this nurse and CNAs assisted resident from floor; vitals were started, doctor notified and POA notified. 2/9/2023 6:47 PM, CNA was walking, passed resident's room, and found him on floor with wheelchair next to him; CNA notified this nurse and this nurse assessed resident; no apparent injuries were found; resident was assisted into another wheelchair and neuros were started; MD and POA notified; nursing supervisor/DON/Administrator notified. 2/10/2023 4:38 PM, resident witnessed ambulating and going to door frame and slowly sitting himself on the floor. Resident yelled for writer. Skin	S9999		

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S9999	Continued From page 14 assessed; active range of motion performed with no pain noted. POA, MD, and DON aware. Resident fully dressed in anti-skid socks. Incontinent brief is dry, drink and snack at bedside. Fall mat on the floor. Resident was unable to tell writer what he was doing ambulating. 2/16/2023 2:49 PM, Resident slid out of chair by nursing station according to staff, who helped resident up from the floor. Witness stated there was no injury to resident. Resident appears relaxed and in no pain and or distress. Vitals were taken and updated into the resident's chart. Currently, the resident is on neuro checks from previous fall on night shift. This appears to be a normal thing for the resident, will continue to monitor for and change in condition or level of consciousness of the resident. 2/20/2023 4:00 PM, Patient fell. Fall was unwitnessed. Patient did not state how he fell. Writer was passing evening medications on A-Hall. Writer looked down the hall and saw staff gathered around patient. When writer approached, patient was sitting upright, knees to chest. Patient was relaxed. Upon assessment patient had a bump on the back of his head. Skin intact. Patient was sent to ER per staff request. 2/20/2023 7:20 PM, resident returned to facility from the ER, resident has no new orders. Nothing found in test at hospital. Neuros continued. 2/25/2023 2:52 PM, see SBAR assessment for further information and family/physician notification. The change in condition the resident is currently experiencing is a fall. CNA said that they heard a loud noise and found resident laying on the floor with back against the wall next to head of bed. On 2/28/23 at 1:40 PM, R3 was observed in bed, pleasantly confused, unable to provide any details of his falls. There was no non-skid material in R3's wheelchair and R3 was wearing regular	S9999		

Illinois Department of Public Health

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S9999	Continued From page 15 socks, not gripper socks. The facility Resident Council Notes, dated 12/7/22, documents call lights were being put out of reach. The "Fall Policy", dated 9/17/19, documents "Following any falls, the facility staff completes an occurrence report. Details of the fall will be implemented, and the care plan will be updated. (A)	S9999		