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
	IL6001473	A. BUILDING: ______ B. WING ______	C 01/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE CENTER	501 CLINTON STREET CARLYLE, IL 62231

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S 000	Initial Comments Facility Reported Incident of 1/19/20 / IL 119499	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest	S9999	**Attachment A** **Statement of Licensure Violations**	

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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.
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 300.3240 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)

These requirements were not met evidencded by:

Based on interview, and record review, the facility failed to provide required supervision during toileting for 1 (R3) of 3 residents reviewed for falls in the sample of 3. This failure resulted in R3 falling from the toilet and sustaining a lip laceration requiring sutures, impacted tooth into the gum, pain management, and emergency medical evaluation and treatment.

Findings Include:

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Review of R3's Clinical Record documents, among other diagnoses, a diagnosis of "Progressive Supranuclear Ophthalmoplegia." According to the National Institute of Neurologic Disorders and Stroke (https://www.ninds.nih.gov/Disorders/Patient-Caregiver-Education/Fact-Sheets/Progressive-Supranuclear-Palsy-Fact-Sheet), "Progressive supranuclear palsy (PSP) is an uncommon brain disorder that affects movement, control of walking (gait) and balance, speech, swallowing, vision, mood and behavior, and thinking. The disease results from damage to nerve cells in the brain. The disorder's long name indicates that the disease worsens (progressive) and causes weakness (palsy) by damaging certain parts of the brain above nerve cell clusters called nuclei (supranuclear)."

A Facility Policy titled, "Fall Risk Assessment" with a review date of 8/29/17 documents, "Each resident will be assessed to determine his or her risk of falling. Residents who score 10 or above of the Fall Risk Assessment are high risk for falls will be reviewed for interventions to reduce their risk."

R3's "Fall Risk Assessment" completed 1/6/20 documents a score of 13, indicating she is "high risk."

Review of R3's Plan of Care documents a focus area with an effective date of 1/8/19 stating, "Falls: I have a potential for falls or injury from falls R/T (related to) unsteady gait and poor balance." An intervention related to the fall focus area includes, "Staff were educated on not leaving the resident on the toilet by self," with an effective date of 3/21/19. R3's Plan of Care also includes a focus area of, "Restorative Transfer

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Program: I have impaired transfers due to weakness and poor balance R/T Progressive Supranuclear Ophthalmoplegia."

R3's MDS (Minimum Data Set) dated 1/10/20 documents R3 is cognitively intact. R3's functional status for toilet use, which includes the defined area of how the resident uses the toilet room, and transfers on/off toilet is scored as "3 (Extensive assistance), 2 (One-person physical assist)." The same MDS documents in all sections of G0300 which identifies R3's "Balance during transitions and walking" including "moving on and off toilet," as a "2 (Not Steady, only able to stabilize with staff assistance."

An "Accident" report dated 3/19/19 regarding R3 documents R3 was noted lying on the bathroom floor in her room. "Corrective Actions Taken" is documented as: "Educated staff not to leave resident on toilet without observation due to spastic movements." "Witnesses" on this report include V3 (Certified Nurse Assistant/CNA).

A serious injury incident report submitted to the state regulatory agency documents that on 1/19/20 at 6:15 AM, R3 was assisted to the toilet for AM care. A CNA determined that V3, stepped out of the bathroom area where R3 was, and into the bedroom space. R3 fell from the toilet resulting in a laceration to her upper lip and discoloration to her nose. R3 was transported to the local ED (emergency department) for evaluation and treatment via ambulance.

"Progress Notes" dated 1/19/20 documents as reported in the serious injury report submitted to the state regulation agency that R3 sustained a fall on 1/19/20 at 6:15 AM from the toilet. The note made by V4 (Licensed Practical Nurse/LPN)

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S9999	Continued From page 4 documents upon initial evaluation a laceration to R3's upper lip with discoloration to her nose was noted. V4 documents R3's VS (Vital Signs) as being BP (Blood Pressure) 184/104, Pulse 81, Temperature 97.1 degrees Fahrenheit, Respirations 18, and her pupils being equal and reactive to light and accommodation. V4 goes on to document at 6:30 AM V11 (On call Physician) returned his call and was notified of R3's fall and status with orders given to send her to the ED. V4 documents the local ambulance service was notified of need to transfer at 6:35 AM, with the ambulance arriving at 6:45 AM for transfer. V4 documents R3 returned to the facility at 12:45PM on 1/19/20. The "ED Note" dated 1/19/20 documents R3 presented to the ED after "She was reportedly sitting on the toilet and fell forward striking her face. Pt. (patient) has limited use of her upper extremities and would be unlikely to guard self during the fall. Pt. communicates using Yes/No boards. She indicates that she has a ha (headache), facial pain, mouth pain. She denies all other complaints." "Physical Exam" document R3 has a 3 cm (centimeter) laceration upper mid lip, left front tooth impacted into gums with base visible. "Skin" documents "Erythema to midface," along with "Psychiatric" documents R3 as being "tearful." The ED Note documents a CT (computed tomography) of the cervical spine, facial bones, and head all without contrast were complete with no significant findings in relation to the injury noted. Diagnoses given post ED evaluation are documented as, "Midface trauma with lip laceration and dental injury. Spoke with V10 (Dentist). He advised that tooth is not likely salvageable. To f/u (follow up) with dentist as outpatient this week." In addition to R3's current physician orders, ED discharge orders included	S9999		

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S9999	Continued From page 5 Amoxicillin 250 mg (milligrams) / 5 ml (milliliters), take 10 ml three times a day for 10 days, and hydrocodone-acetaminophen 5-325 mg by mouth every 8 hours as needed for pain for 3 days. Under the category of laceration repair: upper interior lip, 3 cm long by 4 cm deep, repair method sutures. Review of R3's current "Physician Orders" documents an order dated 8/15/18 in which R3 already receives Tramadol 50 mg by mouth, three times a day for pain management. Review of the Medication Administration Record documents R3 has received a dose of hydrocodone-acetaminophen 5-325 mg on 1/22/20 at 10:21 am in association with mouth pain. The MAR also documents R3 was given a dose of her as needed Acetaminophen 325mg on 1/21/20 at 4:05 AM in association with complaints of pain. On 1/24/20 at 9:25 AM, V3 states she has worked at the facility approximately 6 years and is familiar with the residents. V3 states on 1/19/20, she responded to R3's call light and was getting her up to get dressed and ready for breakfast. V3 describes R3 as not being confused and able to make needs known. V3 states she had sat R3 on the toilet in R3's room and turned on the water to help R3 initiate urination. V3 states she waited for a short amount of time, and R3 had yet to urinate, but communicated no when asked if she was done. V3 states she instructed R3 that she was going to start getting her roommate ready and would be right back in to check on her. V3 states she exited the bathroom and began tending to the roommate within R3's room. V3 states a couple minutes later, she turned around to see R3 in process of falling forward and witnessed her hit her head directly on the floor. V3 states she	S9999		

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S9999	Continued From page 6 notified the nurse and R3 was sent to the ER as she was bleeding from her mouth. V3 states she does not recall R3 as having a history of falls. V3 states once R3 fell she stated, "I lost my balance." V3 states R3 is verbal for small phrases only and uses a communication board also. V3 states R3 walks with assistance in her room and uses a wheelchair for transport to the dining room. On 1/24/20 at 10:24 AM, R3 did not verbally respond when spoken to, although making eye contact. The Yes/No communication board observed on bedside table was utilized in which R3 demonstrated she is cognitively intact, being alert and oriented to person place and time. R3 was asked: Do you recall falling? - yes Do you fall frequently? - no Have you fallen in the past? - yes Do staff usually stay by you when you use the restroom? - yes Was a staff member by you when you recently fell? - yes Was she directly by you where she could have prevented the fall? - no Did you experience pain with your fall? - yes Are they giving you pain medication since your fall/controlling your pain? - yes Do you have sutures to your lip? - yes Are you in pain now? - no Were you scared when you fell? - yes Are you happy with your care at the facility? - yes Did you lose your balance causing you to fall on 1/19/20? - yes Do staff keep your call light within your reach for use? - yes Are you able to eat ok with your lip/dental injury? - yes	S9999		

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S9999	Continued From page 7 On 1/24/20 at 11:55 AM, V9 (Nurse Practitioner) states she is the representative for V8 who is R3's Primary Care Physician. V9 states she is familiar with R3 and saw her on 1/23/20 at the facility. V9 states based on R3's previous history of falls, diagnosis of Progressive Supranuclear Ophthalmoplegia, and current ambulation/transfer/health status, she does not feel R3 was safe to be left alone on the toilet. When V9 read the fall care plan intervention of staff not leaving R3 on the toilet by herself, V9 states she would find that to be an appropriate intervention, which should have been maintained. V9 acknowledges given staff's immediate presence while on the toilet 1/19/20, R3's fall and injuries would have been avoidable. On 1/24/20 at 2:00 PM, V1 (Administrator) states after reviewing R3's Clinical Record and fall history, she is in agreement and acknowledges that R3 should have had staff present at the time of her fall, while on the toilet on 1/19/20. V1 states she just hadn't recalled R3 having a fall in 3/2019 with the intervention of having staff present during toileting being initiated. On 1/24/20 at 1:02 PM V2 (Director of Nursing) states V5 (Family Member) did not want a follow up dental appointment made for R3. V2 states the tooth is still intact currently, with R3 having no complaints of pain. (B)	S9999		