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 _____	05/17/2022

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

(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 Annual Certification and Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations I of II: 300.610 a) 300.1210 a) 300.1210 b)5) 300.1210 c) 300.1210 d)6) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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 _____	05/17/2022

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

(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
S9999	Continued From page 1 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. 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. 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: 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. This REQUIREMENT is not met as evidenced by:	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 2 Based on observation, interview, and record review the facility failed to ensure interventions to prevent falls were appropriately implemented for 1 of 8 (R65) residents reviewed for falls in the sample of 43. This failure resulted in R65 falling out of bed sustaining a comminuted intra-articular fracture of distal femur. Findings Include: R65's facility face sheet dated 5/17/22 documents R65 was admitted to the facility on 10/28/2018 with diagnoses that include acquired absence of right and left leg below the knee, heart failure, atrial fibrillation, chronic pain, diabetes, and muscle spasms. R65's Minimum Data Set (MDS) dated 4/29/2022 documents R65 has a Brief Interview for Mental Status (BIMS) score of 15, which indicates R65 is cognitively intact. R65's MDS documents under section G that R65 requires assist of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R65's fall risk assessments documents a score of 15 on 4/6/22 and a score of 20 on 4/10/22 which indicate R65 is at high risk of falls. R65's care plan with a revision date of 4/25/22 documents "I have a potential for falls or injury from falls R/t (related to) the use of anti-psych (psychiatric) medications and my history of falls. Goals- I will have no injury from falls by: Long-term ..." 6/11/19 interventions are documented as; keep bed in lowest position, complete fall assessments as needed, assess area for hazards, invite and escort to planned activity, ensure glasses are clean, monitor for behaviors, ensure call light is in reach, monitor	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 3 lab values, monitor diet, monitor for side effects, ensure adaptive equipment is being used properly, do medication review, and monitor for signs/symptoms of pain. 1/5/21 intervention is documented as R65 is to be transferred using a mechanical lift and assist of two staff. 4/11/21 intervention documents, "4/6/22 Fall; Noted fall resulting in fx (fracture) to L (left) femur. Resident (R65) was sent to ER (emergency room) for eval (evaluation) cont. (continue) with brace to LLE (left lower extremity). Intervention: Fall mat to be beside bed, body pillow for proper positioning in bed ..." Under interventions the care plan documents "4/10/22 Fall: Noted fall with no apparent injuries noted. R65 is alert and able to make needs known. Intervention: Staff to ensure proper positioning in bed and MD (physician) to be updated regarding meds R/T (related to) increased confusion ..." On 5/11/22 at 11:36 AM, R65 stated she was asleep in her bed (on 4/6/22) and woke up when she hit the floor and heard a loud crunch. R65 stated she broke her femur and had broken the other leg in the exact same way before. R65 stated after she fell and broke the first leg the facility put a mat on the floor by her bed. When asked if the mat was on the floor when she fell the second time, R65 stated it was not. R65 was observed sitting in her wheelchair with bilateral below the knee amputations and a brace noted to her left lower extremity. R65's facility Accident report dated 9/8/21 documents at 5:10 AM, R65 rolled out of bed onto the floor. Under outcome, the report documents R65 had pain to her right kneecap, an abrasion to her right stump and on right side of head. Under contributing factors, the report documents "bed in high position, no call light and motorized	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 4	S9999		

wheelchair parked right up against head of bed in front of AC unit." Under corrective actions taken the report documents "Neuro's initiated, ...X-ray coming out to x-ray right knee cap. MD (physician) updated with new orders to send to ER for Eval, (R65) was seen and x-ray obtained with results of FX (fracture) to R (right) femur with orders to cont. (continue) pain meds as ordered and refer to ortho (orthopedics) ..." Under measures to prevent recurrence the report documents "Educate resident on keeping w/c (wheelchair) out of room when plugged in. Educate staff on keeping bed in lowest position and ensuring resident has call light within reach."

R65's 9/8/21 right knee x-ray report documents under impression: "1. Acute mildly displaced transverse fracture involving the distal femur with associated hemarthrosis, 2. Diffuse osseous demineralization suggesting underlying osteopenia/osteoporosis ..."

R65's hospital after visit summary dated 9/8/21 documents diagnosis as "broken leg."

R65's facility fall risk assessment dated 9/8/21 documents "Noted fall with FX (fracture) noted to R (right) femur after x-ray done at ER. Staff to ensure bed is in lowest position and fall mat applied. Staff to ensure elder is properly positioned in bed. See goals. Elder was referred to ortho. Will monitor."

R65's progress notes document the following: 4/6/22 at 3:10 AM documents, "Note: (R65) was yelling and upon entering room (R65) was on right side in floor beside bed. (R65) stated, "I rolled out of bed." (R65) stated that no injury (sic) and did not hit head. (R65) (mechanical lift) into recliner. ROM (range of motion), LOC (level of

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 _____	05/17/2022

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

(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
S9999	Continued From page 5 consciousness), and neuros WNL (within normal limits) for (R65). Fall mat placed beside bed. Resident encouraged to lay in the middle of the bed r/t (related to) resident is a double BKA (below knee amputee) ..." 4/6/22 11:17 AM "Note: Shift f/u (follow up) for fall. During assessment this morning resident was calm and sleeping in recliner with c/o (complaints of) little pain to left knee. About an hour later resident became tearful complaining of severe pain to left knee stating, "I'm afraid it's broken." No warmth, bruising, redness or obvious signs of injury at site. Left knee slightly more swollen than right knee. Able to move left lower extremity. Noted large purple knot/hematoma on left forearm. Denies pain to arm, stated, "I didn't even know it was there .... V17 (physician) was updated on complaints of pain to LFA (left forearm) and L (left) knee. New order for STAT X-ray to both sites ..." 4/6/2022 8:17 PM "Note: 1:00 PM ...Updated on x-ray results with N.O. (new order) to send to ER (emergency room) for further imaging, eval (evaluation), and tx. (treatment)." R65's facility accident report dated 4/6/22 documents at 2:40 AM under description, "Resident rolled out of bed." Under Outcome: "No apparent injury neuros started." Under Contributing factors: "Resident mental (resident was sleeping)." Under Corrective Actions Taken: "Fall mat placed beside bed." Under measures to prevent recurrence: Fall mat beside bed. Bed in lowest position. Encourage resident to stay in the middle of the bed." R65's radiology report dated 4/6/22 documents an examination of pelvis, left hip, left femur, and left knee at 2:52 PM. Under clinical history the report documents, "Trauma. Fell from bed.	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 6 Previous below-knee amputation." Under Impression the report documents, "Comminuted intra-articular fracture of the distal femur." R65's hospital after visit summary dated 4/6/22 documents fall as the reason for visit and "closed displaced fracture of distal epiphysis of left femur ..." On 05/13/22 at 11:56 AM, V14 (Certified Nursing Assistant/CNA) stated she was not working when R65 fell. V14 stated R65's fall interventions are a floor mat, bed in lowest position, and to ensure the call light is in reach. V14 stated the floor mat has been in place for a while and is not a new intervention. On 5/13/22 at 12:12 PM V19 (Licensed Practical Nurse/LPN) stated she was working the night R65 fell and fractured her leg in April of 2022. V19 stated R65 was in her bed and the facility staff heard her yelling. V19 stated when they entered R65's room she was on the floor. V19 stated R65 was laughing and stated she fell out of her bed. V19 stated she assessed R65 and R65 did not have any complaints. V19 stated she was off work the next day and when she came back, she was told R65 had started complaining of pain and was sent to the hospital for evaluation. When asked what interventions were put in prior to R65's fall, V19 stated she had a high/low bed and mats on the floor. When asked if that was all in place when R65 fell V19 stated it was. On 5/13/22 at 1:10 PM, R65 confirmed the mat was not on the floor when she fell out of the bed on 4/6/22. On 5/13/22 at 1:37 PM, V20 (CNA) stated she	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 7 was working the night (4/6/22) R65 fell and fractured her leg. V20 stated she heard yelling and went to check on R65 and she was laying on the floor. V20 stated she moved the floor mat and the wheelchair and then got the mechanical lift and got R65 up and back into bed. When asked if R65 was laying on the floor mat when she found her, V2 stated, "Umm, I want to say she was, but I can't quite remember because I have a bad memory." When asked if she was R65's CNA that night, V20 stated she was. When asked if she assisted R65 to bed that night V20 stated she couldn't remember. On 5/13/22 at 1:47 PM, V2 (Director of Nurses) stated she didn't think there was a mat on the floor when R65 fell on 4/6/2022. V2 stated R65 always refuses the mat. V2 stated she would expect the mat to be in place when R65 is in bed. On 5/13/22 at 2:38 PM, V21(MDS/Care plan Coordinator) stated on 4/6/22 when R65 fell and fractured her leg she received a call from the staff notifying her of the incident. V21 stated she was told the mat was not on the floor beside the bed when R65 fell. V21 stated R65 is not a fan of the fall mat and likes to sleep in her chair at times. V21 stated R65 is alert and oriented and her BIMS is always 15. V21 stated R65 would not be able to transfer herself or move the floor mat herself. On 5/18/22 at 8:30am, V17 (R65's Physician) stated a fall mat on the floor beside R65's bed may not have been 100% effective in preventing R65's fracture, but it would certainly have lowered the possibility of a fracture. V17 stated it is his expectation that the facility will consistently implement fall precautions.	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 8 The facility Falls-Clinical Protocol dated March 2018 documents under "Cause Identification 1. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall ...." Under Treatment/Management the protocol documents, "1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling .... The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequence of falling. A. Frail elderly individuals are often at greater risk for serious adverse consequences of falls. B. Risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented." "A" Statement of Licensure Violations II of II: 300.610 a) 300.1210 b)4) 300.1210 c) 300.1210 d)2) 300.2040 b)2) 300.2040 d) 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	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 9 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 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. 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. 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: 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.2040 Diet Orders	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 10 b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian. 2) The diet shall be served as ordered. d) The resident shall be observed to determine acceptance of the diet, and these observations shall be recorded in the medical record. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and record review, the facility failed to provide prescribed nutritional supplements and meals as ordered for 3 (R23, R24, R38) of 7 residents reviewed for nutritional services in the sample of 43. This failure resulted in R24 suffering a 7.95% weight loss over the past 3 months. B. Based on observation, interview and record review, the facility failed to check the placement of an enteral tube before initiating a feeding, to monitor monthly and weekly weights, and to provide the correct amount of enteral feeding as per Dietician and Physicians orders for one tube fed resident with significant weight loss (R48) of one resident reviewed for enteral feeding in the sample of 43. This failure resulted in R48 losing a total of 30 pounds between 12/21/21 and 4/6/22. Findings Include: 1A. On 05/11/22 at 09:47 AM, R24 was observed in his room, sitting in his wheelchair. An interview with R24 revealed R24 was alert to person only. R24's current physician orders documented active diagnoses including but not limited to	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 11 shortness of breath, constipation, altered mental status, anorexia, and pain. R24 is documented as admitting to the facility on 9/9/21 from an Assisted Living Facility. Review of R24's weights in his Electronic Health Record documented the following entries: 146.4 lbs (pounds) - 11/03/2021 158.9 lbs -12/02/2021 149.7 lbs - 02/02/2022 149.8 lbs - 03/02/2022 141.9 lbs - 04/06/2022 137.8 lbs - 05/04/2022 When calculated, this shows R24 has had a 7.95% weight loss in the past 3 months. On 5/17/22 at 9:58 AM, V2 (Director of Nursing/DON) stated that R24 did not have a January 2022 weight documented. V2 confirmed R24 was present in the facility during January and is unsure why a weight was not obtained for that month. Review of R24's Physician Order's documents an active order with an original order date of 2/21/22 for "House Supplement TID (three times a day)." R24's dietary orders also include an order with a 1/5/22 original order date for "Diet order changed to mechanical soft with nectar thick liquids" and "Monitor Weight" stating to schedule "every month on the 1st Wednesday at 5:00 AM - 5:00 PM" with the original order date being 12/20/21. Review of V8's (Registered Dietitian/RD) most recent dietary note entry dated 4/13/22 documents R24's Ideal Body Weight is between 139-169 pounds. V8's entry stated she recommends continued diet therapy, continue supplements, 2cal (calorie) med pass 60 cc (cubic centimeter) tid (three times daily),	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 12 encourage oral intake, with no weight decrease desired. Review of R24's Plan of Care documents a problem area with an effective date of 9/25/21 which stated, "I am at risk for inadequate nourishment R/T (related to) my dx (diagnosis) of pain and SOB (shortness of breath)." Interventions listed for this plan of care include: "Provide my diet order TID and PRN (as needed);" "Monitor my intake of all meals." On 05/11/22 at 12:31 PM, R24 was served a meal tray of broccoli, ground chicken with mushroom sauce, buttered egg noodles, and glazed apple cake. Review of R24's meal ticket served with his tray documents bread and margarine should have also been included, which is not observed on the tray. Along with the bread and margarine, no house supplement was observed to be served with the meal. On 05/11/22 at 12:43 PM, V5 (Dietary Aide) stated bread and butter is listed on the diet tickets/menu for R24 today and acknowledged it was not served. V5 stated she has it in the cabinet and residents can ask for it if they want some. V5 stated house supplement drinks are served with meals by dietary or CNA (Certified Nursing Assistant) staff when serving trays. V5 acknowledges no house supplement drinks were served to anyone in the 2nd floor dining room during lunch time today, which includes R24. V5 confirmed the error and stated she will get the supplements served to residents. On 5/13/22 at 8:46 AM, V8 (RD) stated that house supplements are given to residents during meals by the kitchen staff. V8 stated that foods listed on resident's meal ticket should be served	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 13 unless the resident specifically has requested not to receive that food. V8 stated that the lack of residents receiving house supplements or diets as ordered can be a factor with weight loss as those are just "missed calories." V8 stated she would expect residents to be receiving house supplements along with foods listed on their diet card corresponding with their diet as prescribed. V8 stated when reviewing R24's food intake log which is completed by the CNA's, there are very few entries. V8 stated from 5/7/22 - 5/12/22 between all 3 meals served in a day, there are only 5 entries made in total for food intake percentages for R24. V8 stated intakes should be documented each meal. On 5/13/22 at 4:30 PM, V12 (Physician) stated that he would expect R24 to be receiving his diet and nutritional supplements as ordered. V12 stated he was aware R24 had experienced weight loss. V12 stated that R24 had previously had Covid, which seemed to take a declining toll on his health. V12 stated while the supplements may or may not provide R24 weight gain, V12 confirms he would expect them to be provided in an effort to prevent further loss. Review of R24's Minimum Data Set (MDS) dated 3/29/22 documents a Brief Interview for Mental Status (BIMS) the score of 99, which indicates the resident was unable to complete the interview. Section G of the same MDS documents under the section titled "eating" that R24 required limited assistance of one-person physical assist 2A. R23's Face Sheet documented diagnoses in part of major depressive disorder, Gastro-esophageal reflux disease without esophagitis, Hypokalemia, Type 2 diabetes with	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 14 hyperglycemia, Hemiplegia, unspecified left dominant side. R23's MDS dated on 3/26/2022 documented a BIMS score of 15, indicating he is cognitively intact. Section G of the same MDS under the section titled "eating" documents set up with one assist needed. Section K documents no swallowing disorder but has a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. R23's Physician Orders Sheet documented, "House supplements Three times a day ordered on 5/10/2022" R23's Physician Orders Sheet documented, "Ice Cream at Lunch and Supper ordered on 3/17/2022. On 05/11/22 at 12:54 PM, R23 did not get a house supplement or ice cream served for lunch as indicated on his menu card. R23 was served ice cream after surveyor asked V18 (Restorative Aide) if he should have ice cream served. On 5/11/2022 when surveyor asked V18 if (R23) was supposed to get ice cream and a house supplement served as indicated on the menu card, V18 asked (R23) if he would like the ice cream for lunch and R23 stated yes. V5 (Dietary Aide) stated (R23) should have been served ice cream and a house supplement as indicated on his menu card. V5 stated "Yes if the diet card has to serve ice cream and house supplement it should be served with the meal." On 05/13/22 at 9:52 AM, V8 (RD) stated, if (R23's) menu card had house supplement three times a day, she would expect dietary staff to	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 15 serve the supplement at all three meals. V8 also stated that if the diet card has ice cream on it, they should be serving the ice cream too. 3A. R38's Resident Face Sheet documented diagnoses in part, Unspecified injury at C4 level of spinal cord, hypertension, Gastro-esophageal reflux disease without esophagitis. Vitamin Deficiency, Immobility syndrome (paraplegic). Permanent atrial fibrillation; Nonrheumatic aortic (valve) stenosis; Presence of cardiac pacemaker, and Chronic Kidney Disease. R38's MDS dated 4/9/2022, documents a BIMS score of 15, indicating R38 is cognitively intact. Section G of this same MDS documents R38 requires limited assistance with eating by one staff member. Section K documents no swallowing disorder but has weight loss of 5% or more within the last month. R38's Physician Orders Sheet (POS) documented, "House Supplements three times a day" ordered on 5/4/2022. On 05/11/22 at 11:38 AM, R38 stated he has lost weight over the last 6 months. R38 also stated, the food does not taste good because it is often over cooked or undercooked. On 5/11/2022 at 12:30 PM and 5/12/2022 at 12:07 PM, R38 was eating lunch and did not have a house supplement served. R38's menu card did not have a house supplement listed. On 05/13/22 at 8:48 AM, R38 was eating breakfast and he still did not have a house supplement served or a house supplement listed on his menu card.	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 16 On 5/13/2022 R38 stated, he does not get a house supplement. R38 also stated he was not aware he was supposed to be getting a house supplement with his meal. On 05/13/22 at 9:52 AM, V8 (RD) stated, (R38) should be getting a house supplement with his meals per the doctor's order written on 5/4/2022. On 05/13/22 at 11:25 AM, V1 (Administrator) stated, V2 (DON) sends the registered dietician's recommendations to the doctor to get them approved which is usually done within a few days. V1 also stated, usually in their morning meetings (V2) will let her know the dietary recommendations were approved, and she will update the resident's menu cards for the kitchen staff thereafter. V1 stated, she was not aware of (R38's) diet order for house supplement three times a day and she would check into this. V1 also stated, there is no policy on supplements. 1B. A Face Sheet documented that R48 was admitted to the facility on 11/17/21 with diagnoses including Parkinson's Disease, Alzheimer's Disease, and a Gastrostomy tube. (g tube.) R48's Care Plan with a review date of 4/13/22 documented a problem area, "I am at risk for inadequate nourishment...", with a corresponding goal, "I will maintain my weight between 135 pounds and 140 pounds," and intervention, "Monitor my g tube feeding formula and ensure it is adequate and consult with Registered Dietician.." R48's May 2022 Physicians Order Sheet (POS) documented an order for (trade name) enteral	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 17 feeding solution, 1.2 calories per ml (milliliter), infuse 75 ml every hour via pump. NPO (Nothing by mouth). This POS did not document an order as to the frequency of weight monitoring. The same POS documented, "Stage 2 pressure wound to the right buttock." On 05/11/22 at 8:51am, R48 was observed in her room. R48 appeared thin, with contracted limbs. R48 was alert but not oriented to person, place, or time, and most of her answers were unintelligible. An enteral feeding pump was infusing a trade name 1.2 calorie per ml enteral feeding supplement at a rate of 75 ml per hour into R48's g tube. On 05/11/22 at 10:33 am, V15 (Licensed Practical Nurse/LPN) was observed changing the tubing and initiating a new container of R48's enteral feeding. V15 turned off the pump and unhooked the pump tubing from the g tube port and removed the empty container of solution. V15 took a new tubing set up and inserted it into the new feeding solution container. V15 then hooked the tubing to the g tube port and restarted the pump, and the feeding began infusing. V15 did not check for g tube placement, either by auscultation or checking for residual gastric contents, prior restarting the feeding. A Gastric Tube Feeding Policy dated 8/29/17 documented, "Aspirate the feeding catheter using a syringe to determine proper placement, (then) attach feeding solution tubing to gastric tube." On 05/12/22 at 03:05 PM, V15 stated g tube placement should be checked via auscultation and by aspirating residual gastric contents, "Anytime you are getting ready to put anything into the g tube, either medications, or a feeding."	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 18 R48's Weight Record documented the following weights: 12/22/21: 136 lb (pounds) 3/2/22: 114 lb 4/6/22:106 lb 5/4/22:112 lb There was no documentation of January and February 2022 weights. An Admission Nutrition Assessment dated 11/17/21 documented, "Current (admission) weight 135 lb. Ideal body weight 103-127 lb. Small (pressure) area to coccyx. (Receiving) (trade name enteral feeding) 1.2 calorie per ml 65ml per hour." Progress Notes authored by V8 (Registered Dietician/RD) documented the following: 12/20/21: "December weight pending. (Receiving) (trade name enteral feeding solution) 1.2 calories, infuse 65ml per hour for an estimated 23 hours. Recommend current tube feeding." 1/12/22: "December weight 136lb. Continue diet therapy. (January weight was not documented in this note). 2/25/22: "December weight 136lb. Continue diet therapy. (February weight was not documented in this note). 3/21/22: "March weight 132 pounds, December (2021) weight 136 pounds. Increase (feeding rate) to 75ml per hour." 4/27/22: "Resident receiving (trade name enteral feeding) 1.2 calories infuse 75ml per hour. April weight 106 lb, December weight 136 lb. Noted weight loss. Tube feeding was increased to 75ml per hour on 3/21/22. Recommend continue tube feeding, weekly weights, no weight loss desired."	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 19 On 05/13/22 at 9:15am, V8 stated R48 is to receive 75ml of a trade name 1.2 calorie per ml enteral feeding solution every hour via pump, for a total of 1725ml in a 23-hour period. V8 stated an hour off the feeding daily is calculated so as to allow for time in changing the tubing and feeding solution. V8 stated she is not sure why there is an 18 lb. discrepancy between the weight in her 3/21/22 progress note versus the 3/2/22 weight on the resident's weight log in the chart, nor any documentation of January and February weights. V8 stated she depends on getting accurate weights from the staff. V8 stated she was going to evaluate R48 later that day and get back with the surveyor. On 05/17/22 at 8:48am, V15 (LPN) stated the enteral feeding pump records the amount of solution infused, and this amount is to be recorded on the MAR (Medication Administration Record) every 12 hours (once per shift). R48's (MAR) documented the following daily totals for the enteral feeding solution: March 2022: 3/23/22: 1549ml 3/28/22: 1622ml 3/29/22: 1572ml April 2022: 4/19/22: 1699ml 4/20/22: 726ml on the 5am to 5pm shift; on the 5pm to 5am shift,"Not collected." 4/21/22: 1295ml May 2022: 5/8/22: 1704ml 5/10/22: 1823ml 5/12/22: 1718ml	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 20 On 05/13/22 at 9:15am, V8 stated she evaluated R48 on 12/20/21, 1/12/22, 2/25/22, 3/21/22, and 4/27/22. V8 said when she had evaluated R48 on 3/21/22, she was given R48's weight as 134lb, and increased the rate of R41's feeding from 65ml per hour to 75ml per hour to prevent further weight loss. V8 stated she evaluated R48 earlier today and recommended adding a trade name liquid protein supplement 30ml daily to prevent further weight loss. V8 stated the current feeding orders should be enough to meet R48's calorie requirements. V8 stated she cannot account for R48's weight loss except that she may have not taken R48's pressure wound into account when calculating R48's nutritional needs. V8 also stated R48 had Covid in February 2022, and she was not sure if the infection could have contributed to the weight loss. When V8 was shown the above referenced MAR, she stated she could not account for the wide variances in R48's enteral feeding intake. A Progress Note authored by V8 dated 5/13/22 documented, "Current weight 112. No tube feeding problems noted in recent nursing notes. Noted weight loss, (but weight did) increase (from April 2022). Resident had Covid 19 mid-February 2022, possibly contributed to weight loss. (Receiving) (trade name enteral feeding supplement) 1.2 calories 75ml per hour, estimated 23 hours, equaling 2070 calories per day. Compared to nutritional needs, the resident is receiving adequate nutrition with both tube feeding products and rate. Recommend continued tube feeding, add Liquid Protein 30cc daily, no weight decrease is desired ....continued weight increase is beneficial." On 05/17/22 at 08:53am, V2 (Director of Nursing)	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 21 confirmed that R48 has had a significant weight loss since admission. V2 stated she cannot account for R48's weight loss. V2 stated she is not sure why there is an 18lb discrepancy between the 3/2/22 and 3/21/22 weights. V2 stated she is not sure why R48's weight was not documented in January and February 2022. V2 stated she was unaware V8 had previously recommended weekly weights. V2 stated unless there is a physician's order stating otherwise, weights should be checked at least once monthly, and frequency can be increased with nursing judgment as needed. V2 stated she is not sure what accounts for the variance in R48's intakes on the MAR as outlined above. V2 confirmed R48 should receive 1725cc of feeding in a 23-hour period. V2 confirmed the intakes are to be obtained from the feeding pump memory and documented on the MAR every 12 hours. V2 confirmed that R48 had Covid in February of 2022. V2 stated she seemed to recall R48 having a couple episodes of emesis during that time in which her feeding had to be shut off. V2 stated she would check for documentation of this in the nurses' notes. V2 stated R48 did not have episodes of loose stool during that time. V2 stated on occasion, staff will disconnect R48's feeding pump and leave it in her room in order to take her outside when the weather is nice. V2 stated staff do not switch on the battery feature so the pump can be taken outside. V2 stated she could perhaps in-service the nurses to leave the pump on and run it with the battery when R48 is taken outside. V2 stated perhaps the facility could begin monitoring R48's weight more frequently than monthly. V2 made no statements indicating she intended to investigate the varying intakes or weight documentation discrepancy. The facility was unable to present any	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 22 documentation to show that R48 experienced episodes of emesis in February 2022. The facility also did not present any documentation as to R48 being taken outside without her feeding pump. On 05/18/22 at 8:52am, V17 (R48's Physician) verified the tube feeding order as per V2 and V8. V17 stated he has no explanation as to the varying intakes on the MAR as outlined above. V17 stated R48 is NPO, and her daily intakes should be fairly consistent to 1725ml. V17 stated the facility had kept him informed of R48's weight decline.V17 stated a tube fed resident generally will not sustain weight loss. V17 stated a Covid infection, nor a stage 2 pressure ulcer would increase metabolic demand enough to cause a 30lb weight loss. V17 stated his expectation is that the facility should switch the tube feeding pump to battery mode when taking R48 outside if at all possible. V17 stated R48's weight should have been monitored at least monthly, and when the significant weight loss was noted, increasing weight monitoring to weekly per V8's recommendation would have been helpful. V17 further stated the facility needs to investigate the cause of the varying intakes on the MAR. A Resident Weight Policy dated 10/26/17 documented, "...Ongoing weights will be performed monthly and as needed per physician's recommendation which may be changed to daily or weekly depending upon condition change. The facility's goal is to address each individual case for potential interventions to stabilize weight status. The (facility) will follow regulations and report significant weight gain or loss. 5% (percent) in one month, 7.5% in 3 months, or 10% in 6 months."	S9999		

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 _____	05/17/2022

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

(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
S9999	Continued From page 23 "B"	S9999		