STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145323	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrier Mills Nsg & Rehab Ctr	6789 US Rt 45 Carrier Mills, IL 62917

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide the identified level of supervision and assistance required to prevent an accident for 1 of 3 (R1) residents reviewed for accidents in a sample of 9. This failure resulted in R1 falling and having multiple rib fractures.This past noncompliance occurred on 05/06/26.The findings include:R1's admission Record documents an admission date of 08/02/25, with diagnoses in part of unspecified dementia, bursitis of unspecified shoulder, unilateral primary osteoarthritis right hip, primary generalized osteoarthritis, unsteadiness on feet, unspecified abnormalities of gait and mobility, repeated falls, cognitive communication deficit, and other reduced mobility.R1's MDS (Minimum Data Set) dated 02/27/26 documents in Section C a BIMS (Brief Interview for Mental Status) score of 7, which indicates moderately impaired cognition. Section GG documents toileting as partial/moderate assistance. Sit to stand and chair/bed to chair transfers documents partial to moderate assistance. Toileting transfers documents partial to moderate assistance.R1's Care plan documents a focus area with a date initiated of 08/04/25, that states I am at risk for falls r/t (related to) decreased mobility, episodes of incontinence. Interventions include 1. Assist with transfers and ambulation. 2. Staff to remain with resident during ambulation and transfers, PT (Physical Therapy)/OT (Occupational Therapy) to eval (evaluate) and treat, and medication review (05/06/26).R1's fall risk evaluation dated 02/10/26 documents a score of 15 which indicates R1 is at risk for falls.R1's fall risk evaluation dated 05/06/26 documents a score of 5 with the category marked at NA (Not Applicable).R1's Fall report dated 05/06/26 documents under Nursing description: CNA (Certified Nurse Assistant) came and got this nurse, stating that the resident had fallen in her bathroom. Upon entering bathroom resident was sitting on the floor beside the toilet. Asked her what happened and she stated she fell, landing on her bottom. CNA concurred with statement stating resident let go of her walker and fell. Resident's house shoes are too big and may have contributed to the fall. This nurse assessed resident and no apparent injuries. No bruising was noted and resident was able to move all extremities. Neuro checks were WNL (Within Normal Limits). This nurse got another CNA to help and the two CNA's used a gait belt to get resident up and back to her recliner. Resident was walking. C/O (complained of) a sore bottom. In the notes section of the fall report it was documented upon IDT (Interdisciplinary team) investigation it was found on 05/06/26 at approximately 5:11AM CNA entered residents room to assist her to get up in preparation to go to the dining room for breakfast. CNA placed walker in front of residents recliner and resident stood up from the recliner and ambulated to the bathroom with her walker independently with the CNA walking with her as a standby assist which is her baseline status for ambulation for short distances. When resident finished using the bathroom the CNA placed her wheelchair near the bathroom door as resident uses a wheelchair for long distances and was getting ready to go to the dining room for breakfast. CNA was standing near the wheelchair as resident began to take a few steps with her walker towards the wheelchair when resident appeared to have fallen backwards onto the floor. CNA immediately responded and then notified the nurse. Nurse completed a full body assessment, checking range of motion in all extremities and checking for pain, bumps, bruises, etc. No apparent (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	injuries were noted at that time. Staff then assisted resident up in her wheelchair and to the dining room to eat breakfast. Resident had no complaints noted.A final report sent to the Illinois Department of Public Health documents R1 had a fall on 5/6/26 at 5:15AM. The report documents upon IDT investigation it was found on 05/06/26 at approximately 5:11AM CNA entered resident's room to assist her to get up in preparation to go to the dining room for breakfast. CNA placed the walker in front of the resident's recliner and resident stood up from the recliner and ambulated to the bathroom with her walker independently with the CNA walking with her as a standby assist which is her baseline status for ambulation for short distances. When resident finished using the bathroom the CNA placed her wheelchair near the bathroom door as resident uses a wheelchair for long distances and was getting ready to go to the dining room for breakfast. CNA was standing near wheelchair as resident began to take a few steps with her walker towards the wheelchair when resident appeared to have fallen backwards onto the floor. CNA immediately responded and then notified the nurse. Nurse completed a full body assessment, checking range of motion in all extremities and checking for pain, bumps, bruises, etc. No apparent injuries were noted at that time. Staff then assisted (R1) up in her wheelchair and to the dining room to eat breakfast. (R1) had no complaints noted. MD (Medical Doctor) and POA (Power of Attorney) notified of the incident. This report further documents that on 05/10/26 (R1) went on a family outing with her daughter/POA and during that outing resident began complaining of shortness of breath and no quite acting herself, so daughter decided to take her to be seen at the ER (Emergency room). While at the ER (R1) was diagnosed with bronchitis and non-displaced rib fractures. (R1) was treated with antibiotics, nebulizer treatments, and oral steroids at the hospital and was discharged back to the facility on [DATE].R1's hospital records dated 05/10/26 documents in part under CT (Computed tomography) angiogram pulmonary embolism with contrast bony thorax right posterior 9th, 8th, 7th nondisplaced rib fractures, left posterior 11th, 10th nondisplaced rib fractures. Under clinical impression 1. Bronchitis, 2. Multiple rib Fractures, 3. Fall at Nursing home. On 05/19/26 at 1:21PM, R1 stated that she did have a fall recently. R1 said that she was in the bathroom and went to leave the bathroom and fell on the floor. R1 said that she did have staff there in the room with her. R1 said that she hurt everywhere when she fell. R1 said that she went to the hospital on Mother's Day because she was having some problems breathing and they found out she had rib fractures from her fall. R1 said that she doesn't remember if staff had a gait belt on her or not when she fell. On 05/18/26 at 4:44PM, V20 (Family Member) stated that they took R1 to the hospital on [DATE] because she wasn't breathing really well and she was kind of out of it. V20 said that while they were at the hospital they did a CT scan and found out that R1 had multiple rib fractures from her fall on 05/06/26. V20 said that the hospital did keep R1 overnight. V20 said they did have a care plan meeting with V1 (Director of Operations) and V3 (Owner/Director of Operations) along with another regional nurse. V20 said that they have a video camera in R1's room and they reviewed the fall on 05/06/26 with V1 and V3. V20 said that you can hear R1 falling. On 05/20/26 at 11:12AM, V6 (Licensed Practical Nurse/LPN) stated that she did not observe R1 fall it wasn't until V17 (CNA) said that R1 fell that she knew about the fall. V6 said that she walked in and that R1 was sitting on the floor next to the toilet. V6 said that she yelled for the other CNA as well. V6 said that she checked R1's legs for shortening and rotation. V6 said she checked R1' s head for any bumps she said that R1 told her that she did not hit her head. V6 said that the only thing that R1 was complaining about was her back hurt. V6 said that she did a skin assessment and there was no bruising or skin tears noted. V6 said that she did neuro checks on R1 and they were all within normal limits. V6 said she did a good assessment on R1 then she had the other CNA go get a gait belt and then the 2 CNA's used the gait belt and assisted R1 off the floor. V6 said that R1 missed hitting the toilet and the sink in the bathroom. V6 said that she thought maybe R1's house shoes could have caused her to fall because she thought they looked a little too big.On 05/20/26 at 11:48AM, V13 (CNA) stated that they use a gait belt on R1 along with her walker to get her up.On 05/20/26 at 11:48AM, V9 (CNA) stated that R1 used to be on her hall but they moved her a little after the fall. V9 said that R1 would transfer (continued on next page)

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