

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Carlinville Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE 751 North Oak Street Carlinville, IL 62626	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>(continued on next page)</p>

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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<p>F 0607</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their own policy of providing a thorough investigation of abuse by not properly identifying the alleged staff involved for 1 of 3 (R22) residents investigated for abuse in a sample of 23. This failure led to the resident fearing of retaliation by one of the alleged individuals. Findings include: R22's EMR (Electronic Medical Record) undated documents that the resident was admitted to the facility on [DATE]. R22's EMR dated 12/18/23 documents a diagnosis of Major Depressive Disorder, recurrent, moderate. R22's EMR dated 5/18/23 documents a diagnosis of Morbid (severe) Obesity due to excess calories. R22's EMR dated 12/20/23 documents a diagnosis of Chronic Obstructive Pulmonary Disease, unspecified. R22's MDS (Minimum Data Set) dated 11/7/25 documents a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS documents that the resident has little interest or pleasure in doing things 7-11 days (half or more of the days); feeling down, depressed, or hopeless 12-14 days (nearly every day); trouble falling or staying asleep, or sleeping too much 12-14 days (nearly every day); feeling tired or having little energy 12-14 days (nearly every day); poor appetite or overeating 12-14 days (nearly every day); feeling bad about yourself - or that you are a failure or have let yourself or your family down 12-14 days (nearly every day); trouble concentrating on things, such as reading the newspaper or watching television 12-14 days (nearly every day); and moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual 12-14 days (nearly every day). The MDS documents that the resident requires partial/moderate assistance for roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident requires substantial/maximal assistance for sit to stand, chair/bed to chair transfer, and toilet transfer. R22 does not have a care plan for abuse. Facility's Abuse Investigation dated 11/23/25 documents Final Report: On 11/23/25 resident (R22) (DOB: [DATE]) reported two CNAs (Certified Nursing Assistant) were in his room and one of the two stated to him to, shut his fat f***ing mouth. Through description it was initially decided that (R22) was referring to CNA (V25) and she was immediately suspended pending outcome of an investigation. An assessment was completed, and no injuries or concerns were noted. (R22) is his own person. The Ombudsman and (local police department) were notified (CAD [Computer-Aided Dispatch]: 25-38612). An investigation was started, and an initial report was submitted. During the investigative process it was discovered (V25) was incorrectly identified as one of the CNAs in question. The two CNAs identified through further description, subsequent interviews and review of schedules and report times were (V24) and agency CNA (V26). (V24) was immediately suspended and (V26) has been put on the Do Not Rehire list and has no further scheduled shifts. Witness statements were obtained from staff and residents. All residents reported to feel safe in the facility. Resident (R23) reported (V24) to be just rude when interviewed. However, she did state she had not been verbally abused. Resident (R5) reported CNAs (V25) and (V26) to be rude. All interviewed residents stated they had not been verbally abused by any CNA including the three in question. While interviewing resident (R22), he explained he had requested assistance from his CNAs at approximately 3:30am and they became irritated with him. He reported the taller of his CNAs (V24) on the morning of November 21st told him, They don't have time, shut your fat f***ing white mouth. He explained he found it more bothersome as they both continued to walk by his room laughing and taunting him. (V26) did not respond to attempts to be interviewed. (V24) was interviewed and denied the allegation. She explained she had never had an issue with him prior to that night and he had kicked her and (V26) out of his room, cussing at them and calling names. Both LPNs (Licensed Practical Nurse) working the overnight shift stated they were unaware of either CNA being discourteous to (R22). CNA (V28) who was working the same day and shift reported (V24) told her resident (R22) had been racist and cussed at her and CNA (V26). CNA (V28) stated her co-worker, CNA (V24), had disclosed she had shut resident (R22's) door and was going to stay away from him for the remainder of her shift. Resident (R22) has a diagnosis of chronic obstructive pulmonary disease, type 2 diabetes, shortness of breath, cellulitis, paroxysmal atrial fibrillation, morbid obesity, major depressive disorder, unspecified atrial fibrillation, panniculitis, chronic kidney disease - stage 3, need for assistance with personal care, muscle weakness, unsteadiness on feet, left knee pain. After thorough investigation, we did not find evidence to substantiate (R22)'s allegation. However, we did find that CNA (V24) in need of customer service re-education along with CNA (V25). Agency CNA (V26) will continue to be on the facility DO NOT HIRE list. She will not return to the facility as an agency employee any further.</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administer an ordered intravenous, IV, antibiotic, timely transport, and contact prescribing Physician for 1(R2) of 3 residents in the sample of 23. This failure resulted in R2's course of treatment being interrupted, R2 needing to have six additional days of IV antibiotics, and the potential of septic infection. Findings include:R2's undated face sheet documents an admission date of 11/28/2025 and a discharge date of 12/4/2025. Diagnosis include Fournier Gangrene, Chronic Kidney Disease, Bacteriuria, Urinary Tract Infection, Acute Kidney Failure, Malignant Neoplasm of Rectum, Colostomy Status.R2's Minimum Data Set, MDS dated R2's MDS dated [DATE] documents R2 has no cognitive deficits. R2 is dependent for rolling, sitting and transfers. R2's baseline care plan dated 12/4/2025 documents The resident has Catheter: Neurogenic Bladder. Interventions include Catheter Care, Position catheter bag and tubing below the level of the bladder and away from entrance room door. R2's order sheet dated 11/28/2025 Ceftazidime-Avibactam Intravenous Solution Reconstituted 2.5 (2-0.5) GM (Ceftazidime-Avibactam Sodium) Use 0.94 gram intravenously two times a day for antibiotic until 12/08/2025 11:59PM.R2's November medication administration sheets, MARS, dated 11/1/2025-11/30/2025 documents Ceftazidime-Avibactam Intravenous Solution Reconstituted 2.5 (2-0.5) GM (Ceftazidime-Avibactam Sodium)Use 0.94 gram intravenously two times a day for ABT until 12/08/2025 11:59PM. R2's 11/28/2025 PM, 11/29/2025 AM and PM dose, 11/30/2025 AM and PM doses all marked as Hold.R2's December medication administration sheets, MARS, dated 12/1/2025-12/31/2025 documents Ceftazidime-Avibactam Intravenous Solution Reconstituted 2.5 (2-0.5) GM (Ceftazidime-Avibactam Sodium) Use 0.94 gram intravenously two times a day for ABT until 12/08/2025 11:59PM. R2's 12/1/2025 AM and PM doses and 12/1/2025 AM and PM doses marked as Hold. R2's progress notes dated 11/28/2025 at 7:00AM document The nurse reported that R2 was newly admitted to the facility with intravenous, IV, antibiotics for Clostridioides difficile, C diff, and Extended Spectrum Beta-Lactamase, ESBL, in the urine. The pharmacy informed that the ordered antibiotic is not available and cannot be supported. The nurse was advised to contact the hospital or prescribing provider to request an alternative medication. The patient remains stable per the nurse. Rounding provider to follow up. R2's progress notes dated 11/28/2025 at 5:15PM documents Call received from pharmacist at to notify that he cannot supply IV antibiotic until Monday 12/1/2025 due to having to order from a different pharmacy.R2's progress notes dated 11/28/2025 at 5:32PM documents Received call from pharmacist. Pharmacist states that he is unable to obtain IV antibiotic for supply, he is also unable to suggest appropriate interchange due to not having culture and sensitivity for reference. V23, Facility Nurse Practitioner, NP, notified of above, with suggestion to attempt to contact ordering hospitalist for new antibiotic. current order antibiotic to be placed on hold pending new orderR2's progress notes dated 11/29/2025 at 11:32PM document Antibiotic/ESBL urine/CDIFF (Vancomycin) IV antibiotic remains on Hold until Monday. No adverse side effects, ASE, noted from medication, Afebrile. R2 voicing no concerns/complaint/discomforts. Able to make needs and or wants known. IV site free of signs of infection with dressing clean, dry, intact, CDI. R2's progress notes dated 12/1/2025 at 11:57AM document Health Status Note Note Text: call placed to V20, Infectious Disease Physician, at this time to notify of unavailable antibiotic order, message provided to nurse in with patient. awaiting response. R2's progress notes dated 12/3/2025 at 5:04PM documents Received call from nurse V20's office with orders to send R2 back to hospital for continuing treatment of IV antibiotics if unable to obtain from any pharmacy for treatment outside of hospital. Per V20 statement is he will not change the IV medication as it is the only medication that can be used. R2's progress notes dated 12/3/2025 at 6:26PM documents Emergency Medical Services, EMS, in facility, refusing to take resident to Emergency Department, ED.R2's progress notes dated 12/3/2025 at 7:38PM out of town EMS refused at 6:23PM. Out of town EMS refused at 6:25PM. Out of town EMS at 6:36PM refused. Out of town EMS at 7:01PM refused. Out of town EMS at 7:37PM refused. Out of town EMS at 7:42PM refused. Out of town EMS at 7:45PM refused. Out of town EMS at 8:08PM refused. Out of town EMS at 8:18PM refused. On 12/9/2025 at 12:46PM V4, Minimum Data Set, MDS Coordinator, stated R2 was discharged on an IV that is usually only given in hospitals. We got a hold of the Infectious Disease Doctor, IDD, and the IDD wanted R2 to go back to the hospital for the IV med to be given there. Then we had an issue with getting him back to the hospital. We could not get an ambulance to come get him. He was almost 500# and was too big for us to take him in our van. We have our own transportation but R2 was too</p>		