

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145729	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER Carlyle Healthcare & Sr Living		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Clinton Street Carlyle, IL 62231	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the failed to ensure allegations of physical abuse were reported immediately to the administrator of the facility and to the State Survey Agency for 1 of 3 residents (R55) reviewed for reporting of allegation of abuse in a sample of 57.</p> <p>Findings include:</p> <p>R55's Face Sheet, print date of 07/02/25, documented R55 has diagnoses of but not limited to dementia, paranoid schizophrenia, anxiety disorder due to known physiological condition.</p> <p>R55's Minimum Data Set (MDS), dated [DATE], documented R55 is severely cognitively impaired and requires substantial/maximal assistance with bed mobility.</p> <p>V2, Director of Nursing (DON) statement dated 06/22/25, documents V2, Director of Nursing, DON, received a phone call from agency nurse, V35, at 7:43 AM regarding a bruise/skin tear (ST) R55 received. The statement documented V35 stated that she had a gut feeling that the agency Certified Nursing Assistant (CNA), V31 gave resident the bruise/ST. That statement continued that V2 came into the facility and started investigation. The statement documented R55 had a Brief Interview of Mental Status (BIMS) of 99 and was alert to self only. The statement documented V2 assessed R55 and noted the bruise/ST, and R55 did not state she was harmed and did not show any emotional distress at that time. At that time, V2 asked V35 to contact V1, Administrator, and write a statement. The statement documents V35 did not contact V1 or write a statement.</p> <p>R55's Electronic Medical Record (EMR) was reviewed and there was no documentation that the Administrator and/or the State Survey Agency was notified of the allegation of abuse for R55.</p> <p>On 07/02/25 at 9:20 AM, V1, Administrator said with abuse she has to have it turned into the State Survey Agency within two hours and with a fall with major injury she has to have it reported within 24 hours. V1 said had she known about the incident with R55 and V31 she would have reported it immediately to the State Survey Agency.</p> <p>On 07/02/25 at 09:25 AM, V2 said V31 worked on the south hall on the night shift the night of the incident. She said after the incident regarding R55 and V31 the agency nurse, V35 called V2 on the phone while she was driving home and told her she had a gut feeling something happened with V31 and R55.</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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NAME OF PROVIDER OR SUPPLIER Carlyle Healthcare & Sr Living		STREET ADDRESS, CITY, STATE, ZIP CODE 501 Clinton Street Carlyle, IL 62231	
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised date of April 2021, documented 9. Investigate and report any allegations within time frames required by federal requirements.</p> <p>The facility's Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating policy, revised date of September 2022, documented Policy Statement All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. local/state ombudsman. It further documented 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were protected from potential further abuse, after an allegation of abuse. This failure affects 1 of 3 residents (R55) reviewed for abuse allegations in a sample of 57.</p> <p>Findings include:</p> <p>R55's Face Sheet, print date of 07/02/25, documented R55 has diagnoses of but not limited to dementia, paranoid schizophrenia, anxiety disorder due to known physiological condition.</p> <p>R55's Minimum Data Set (MDS), dated [DATE], documented R55 is severely cognitively impaired and requires substantial/maximal assistance with bed mobility.</p> <p>V2, Director of Nursing (DON) statement dated 06/22/25, documented V2, Director of Nursing, DON, received a phone call from agency nurse, V35, at 7:43 AM regarding a bruise/skin tear (ST) R55 received. The statement documented V35 stated that she had a gut feeling that the agency Certified Nursing Assistant (CNA), V31 gave resident the bruise/ST. That statement continued V2 came into the facility and started investigation. The statement documented R55 had a Brief Interview of Mental Status (BIMS) of 99 and was alert to self only. The statement documented V2 assessed R55 and noted the bruise/ST, and R55 did not state she was harmed and did not show any emotional distress at that time. At that time, V2 asked V35 to contact V1, Administrator, and write a statement. The statement documented V35 did not contact V1 or write a statement. The statement did not document if V31 was removed from resident care during the investigation.</p> <p>On 7/02/25, at 9:20 AM, V1 stated V31 worked the night shift that night and she stayed over for a double that day. V1 stated she worked the south hall on night shift and then worked a different hall on the day shift. V1 stated she finished her shift on days and then she didn't come back into the facility until the following Friday after the investigation was completed.</p> <p>On 7/2/25, at 9:25 AM, V2 stated V31 worked on the south hall on the night shift on the night of the incident. V2 stated after the incident regarding R55 and V31, the agency nurse, V35 called V2 on the phone while she was driving home and told her she had a gut feeling something happened with V31 and R55. V2 said she made sure V31 was moved to a different hall to work the day shift. She said she didn't feel like V31 was a threat to any of the other residents, so she let her stay and finish the shift. V2 said after she finished the shift, V321 didn't work back at the facility until the following Friday and the investigation had been completed.</p> <p>The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised date of April 2021, documented 10. Protect residents from any further harm during investigations.</p> <p>The facility's Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating policy, revised date of September 2022, documented 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.</p>		