

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Wabash Senior Living & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 216 College Boulevard Carmi, IL 62821	

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 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to maintain equipment that was present on the crash cart and available for use for 1 of 3 residents (R1) reviewed for emergency events in a sample of 36. This failure has the potential to effect 32 residents (R4-R36) residing in the facility with active orders to attempt resuscitation/CPR (Cardiopulmonary Resuscitation). The findings include: R1's admission Record documents an admission date of [DATE] and includes diagnoses of Acute and Chronic Respiratory Failure with Hypercapnia and Hypoxia, Nonrheumatic Tricuspid Insufficiency, Obstructive Sleep Apnea, Atelectasis, Oxygen Dependent, Pulmonary Hypertension, Peripheral Vascular Disease, and Chronic Kidney Disease. R1'S MDS Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. Section GG documents R1 is dependent on staff for hygiene, bathing, and dressing. Transfers were not attempted due to medical condition. R1's Practitioner Order Form Life-Sustaining Treatment (POLST) form documents R1's signature dated [DATE] and documents V14's (Physician) signature on [DATE]. In Section A, a checkmark is documented for Yes CPR (Cardiopulmonary Resuscitation): attempt CPR, utilize all indicated modalities per standard medical protocol. In Section B, a check mark is documented for Full Treatment: goal is to attempt to prevent cardiac arrest by using all indicated treatments. Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated. R1's Progress Notes authored by V9 (Licensed Practical Nurse) dated [DATE] at 5:05PM documents (name) PT (Physical Therapist) came to get this nurse at 4:30pm r/t (related to) res (resident) being unresponsive, upon entering room this nurse observed resident not breathing, no pulse found. CPR initiated at 4:34pm, 911 called at that time. Paramedic came at 4:40PM, he called ER (Emergency Room) Medical Director, given at 4:47 to stop CPR, resident pronounced dead at 4:47pm. This nurse called responsible party, notified of death. Coroner notified of death, arriving at 5:00 and will discuss arrangements with family. On [DATE] at 1:30PM, V9 (Licensed Practical Nurse/LPN) stated that on [DATE] she was notified by a physical therapist that R1 was nonresponsive. V9 stated she went directly to R1's room and started CPR. V9 stated she was assisted by V11 (LPN) and V11 went and retrieved the crash cart. V9 stated when V11 was preparing to hookup the AED (Automated External Defibrillator) there were no pads in the crash cart and the battery was showing low battery. V9 stated they continued chest compressions until EMS (Emergency Medical Services) arrived. V9 stated she has worked at this facility for the last 6 years. V9 stated she was not sure who checked the crash cart, but she had never checked it. V9 stated she was aware that there was an AED machine on the cart, and she has had training to use the AED machine. On [DATE] at 6:52PM, V11 stated she has worked at the facility for 2 years. V11 stated there has always been an AED machine on the crash cart but she has never had to attempt to use it before [DATE] when R1 was found unresponsive. V11 stated she was summoned to the room immediately when R1 was found unresponsive. V11 stated she ran and got the crash cart while V9 was starting compressions. V11 stated when she returned to the room with the crash cart, she</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 146019	If continuation sheet Page 1 of 4

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>documented. The facility policy titled Emergency Procedure-Cardiopulmonary Resuscitation with a revision date of February 2018 documents under Preparation for Cardiopulmonary Resuscitation 2. Maintain equipment and supplies necessary for CPR/BLS (Basic Life Support) in the facility at all times. An Order Listing Report dated [DATE] documents active orders for life sustaining treatment or all residents residing in the facility. There are 32 residents (R4-R36) on this report with active orders to attempt resuscitation/CPR.</p>		