STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146124	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmi Manor Rehab & Nrsg Ctr	615 West Webb Street 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39744 Based on interview and record review, the facility failed to ensure residents were free from abuse for 2 of 3 residents (R10, R12) reviewed for abuse in a sample of 13. This resulted in R10 experiencing feelings of fear and uncertainty for his safety in his home. Findings included: 1. R10's face sheet documented R10 was admitted to this facility on 8/23/2023 with diagnoses of Traumatic Brain Injury, Cancer and Diabetes Mellitus among others. R10's MDS assessment dated [DATE] documented R10 has a BIMS score of 15 out of 15 total, which indicates R10 is cognitively intact. This same MDS documented R10 has no impairment to upper or lower extremities, does not ambulate and independently uses a wheelchair and/or walker for locomotion. R1's face sheet documented R1 was admitted to this facility on 11/29/2024 with diagnosis of Paranoid Schizophrenia, Major Depressive Disorder and Anxiety among others. R1's MDS (minimum data set) assessment dated [DATE] documented R1 has a BIMS (brief interview for mental status) score of 15 out of 15 total, which indicates R1 is cognitively intact. This same MDS documented R1 has no impairment to his upper or lower extremities, ambulates independently and does not use a wheelchair. On 6/4/2024 at 4:05pm, R10 stated on 5/8/2024 about 5:00pm, he was in his wheelchair, in the dining room, sitting at the dining room table waiting for supper to be served. R10 stated R1 suddenly became agitated started yelling he was God and then started kicking over tables. R10 stated next R1 came over by me and started pounding me on top of the head with his fist. R10 said he was trapped between the table and his wheelchair and could not get away from R1. R10 stated R1 just kept hitting me and it took several staff members to get R1 off of me. R10 stated he did not provoke R1 in anyway and has not really had any trouble from R1 in the past. R1 said the unprovoked attack scared him so he sought an emergency order of protection against R1 and does not want R1 around him ever again. R1 stated V4 (Dietary Manager/DM), V9 (Registered Nurse/RN) and R11 were in the dining room and witnessed the attack. R10 stated he declined to go to the emergency room for evaluation after the attack, but later agreed to get in facility mobile X-rays but they were negative. R10 stated other than a sore spot on his head caused by the top button on his hat being hit against his head when R1 kept hitting him, he did not receive any other injuries. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Carmi Manor Rehab & Nrsg Ctr	615 West Webb Street Carmi, IL 62821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/3/2024 at 2:10pm, V9 (RN) stated she was in the dining room on 5/8/2024 at 5:00pm, passing supper medications. V9 stated R1 suddenly started yelling and saying he was God and kicking over empty tables and chairs. V9 stated R1 was yelling he was a [NAME] (Jewish) and was going to put the spirit into V4 (DM), V9 stated next R1 started hitting R10 on the head. V4 stated it took several staff members to get R1 away from R10. V9 stated the police came to the facility and interviewed R1 and R10. V9 stated R10 got an emergency odor of protection against R1. V9 stated R1 did abuse R10 when he hit him. On 6/3/2024 at 2:00pm, V20 (Certified Nursing Assistant/CNA) stated she was working on 5/8/2024 at 5:00pm. V20 stated everyone was in the dining room waiting for supper to be served when R1 started yelling he was God, kicked over empty tables and chairs and then stared hitting R10. V20 stated R1 was pounding R10, hitting him really hard with his fist. On 6/3/2024 at 2:05pm, V12 (CNA) stated she was working on 5/8/2024 at 5:00pm. V12 stated she was passing out supper trays when R1 started yelling and then attacked R10. V12 stated it took several staff to get R1 off of R10. On 6/3/2024 at 2:35pm, V1 (Administrator) agreed R1 had abused R10. V1 stated immediately after R1 attacked R10, R1 was taken to the emergency room for psychological evaluation, did not return to the facility and was discharged from the facility. V1 stated R1 would not be returning to this facility. A facility document titled State of Illinois, Illinois Department of Public Health-Long Term Care Facility-Serious Injury Incident and Communicable Disease Report with incident date of 5/8/2024 at 5:00pm documents the following in part: Final Report. (R1) allegedly struck (R10) several times while in the dining room awaiting dinner. Physician notified. POA's (power of attorneys) notified. Police notified . (R1) was exhibiting unusual behavior such as repeating things over and over again. He told (V4) that the sandwich was very good. He declined a second one when asked if he wanted another one. He told (V4) that he was a [NAME]. He told (V4) that he was going to out the spirit in (V4). After making the statements, he jumped up and began kicking the table and chairs chanting Kick the devil down. (R1) then hit (R10) on the head multiple times while staff intervened to separate them. 911 was called in order to transfer (R1) to the ER. While waiting for the ambulance to arrive, police arrived and took statements from (R1) and (R10). (R1) was delusional during the entire episode and during the police interview. (R1) told he police that he was God Almighty. (R10) declined ER evaluation. (R10) was assessed by nursing staff and no injuries were noted. (R1) went to the ER and did not return to the facility due to (R10) getting and emergency Order of Protection against (R1). (R1) was placed at a new facility. A handwritten, undated statement from R3 concerning what he witnessed when R1 assaulted R10 documented the following in part: I was eating my supper when out of the corner of my eye I seen R1 punching and attacking R10. (R1) Hit him (R10) several times in the head and cussed at him. (Event date 5/8/2024 at 5:00pm) A handwritten statement, dated 5/8/2024, from R2 concerning what she witnessed when R1 assaulted R10 documented the following in part: While sitting at the dinner table, R1 charged at R10 and started beating R10. The only thing R10 was doing was eating an ice cream sandwich. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Progress note in R10's EHR (electronic health record), dated 5/8/2024 at 19:34 (7:34pm) documented the following: V8 (RN) heard a commotion going on in the dining room, (R1) was hitting R10 with his fist on the head. R10 was trying to get away, it took multiple staff to get R1 away from R10. R10 said he didn't do or say anything, that R1 just came up behind him and started hitting him in the head. Document titled State of Illinois, Circuit Court, Emergency Order of Protection documents R10 was granted an order of protection that began on 5/9/2024 at 10:33am and R1 is not allowed within 500 feet of R10. 2. R12's Face sheet documents R12 has an admitted [DATE] with diagnoses including: Paranoid Schizophrenia, Adjustment Disorder with Mixed Anxiety and Depression, Cerebral Infarction, Other Paralytic Syndrome following unspecified Cerebrovascular disease, Paralytic gait and Abnormalities of gait and mobility. R12's Minimum Data Sheet (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 15 indicating R12 is cognitively intact. R6's Face sheet documents R6 has an admitted [DATE] with diagnoses including Encephalopathy, Cerebral Infarction, Polyneuropathy, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non dominant side, and Acquired absence of left leg below knee. R6's MDS dated [DATE] documents a BIMS score of 15 indicating resident is cognitively intact. R8's Face sheet documents an admitted [DATE] with diagnoses including Metabolic Encephalopathy, Essential Hypertension, Chronic Diastolic Heart Failure, Chronic Kidney Disease, Epilepsy and recurrent seizures and Cerebral Infarction. R8's MDS dated [DATE] section C is not completed therefore no BIMS score is documented. On 06/03/24 at 1:17 PM, R6 stated she does not think it is right that R8 came down to R6 and R12's room and put his arm around R12 and kissed her and nothing has been done about it. R8 came down to their room and sat next to R12, put his arm around her and kissed R12 twice. R6 stated, she told him to leave, but he doesn't understand English. They told V10 (Certified Nurse Aide/CNA) and V12 (CNA) and nothing has been done about it. R8 came back down to their room a couple times, she tried to shoo him away and he came back down, and she threw a shoe at him to keep him from coming in the room. R6 stated, her and R12 told V1 (Administrator) on 05/28/24 and then saw him rubbing a staff members arm and another staff's back, she doesn't feel that is helping when he doesn't understand. R12 is uncomfortable and more nervous about going to activities now. On 06/03/24 at 1:19 PM, R12 stated R8 came down to her room on Memorial Day weekend (05/25/24 - 05/27/24) closed the curtain between her and R6, sat on the bed next to her, put his arm around her and kissed her twice on the lips. R12 stated she told him to leave but he doesn't understand English. R12 stated R6 yelled for staff to help, and they took him out of the room. They told the CNAs (V10 and V12) they did not want him in their room. R12 stated, it scares her when he is down in their room, and she does not want him in there. R12 stated, she does not want R8 to touch or kiss her. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 6/3/24 a handwritten document was provided by the V1 (Administrator) that documents interviews from R6 and R12 regarding and incident with R8. At the top of the documents, it reads Interviews on 5/21/24. R6's interview: He (R8) followed (R12) to our room. (R12) went into the bathroom. He (R8) pulled the curtain and sat down on (R12's) rollator. He (R8) then got up and left the room. Later he (R8) came back in the room. He (R8) sat down on (R12's) bed. He (R8) pulled the curtain both times. We (R6 and R12) both told him to go. R12's interview: He (R8) followed me down here (room). I told him (R8) I had a roommate. He (R8) didn't stop. I went into the bathroom, and he (R8) sat down on my rollator. He (R8) came back to our room again after leaving the first time. He (R8) pulled the curtain and sat on the edge of my bed. He (R8) leaned over and kissed me on the lips two times. I motioned for him to leave. R6 yelled for staff. Staff led him away. On 06/03/24 at 1:38 PM, V1 (Administrator) stated she does not have an investigation for R8 and R12 for abuse. She stated, she did an investigation for wandering for R8. V1 stated, R12 and R6 stated, that R8 kissed R12 twice, during the wandering incident but it was determined the incident was a wandering event not a resident-to-resident sexual abuse or an inappropriate sexual behavior. On 06/04/24 at 2:10 PM, V12 (CNA) stated she was present for the incident between R12 and R8. V12 stated, we (V12 and V10 (CNA)) heard R6 yelling for help, we walked in and R8 was sitting on the bed next to R12 and had his arm around R12, they redirected R8 out of the room and back down the hall. V12 stated, she didn't see anything but R6 told her R8 kissed R12. V12 stated, he went back down there one more time that night about 30 minutes later and a couple times since then that she knows of. They just redirect him back to his room. V12 stated, she does not know if R8 understands them, but he will go with them. They will usually point to things or make motions to things if they are figuring out what he wants, he doesn't speak English. V12 stated, she reported this incident to V22 (Licensed Practical Nurse (LPN)) that evening right after the incident. On 06/06/24 at 2:20 PM, V10 (CNA) stated she was present the evening of the incident with R12 and R8. V10 stated, her and V12 (CNA) were in the room across from R12's room when they heard R6 yell. R8 had his arm around R12 but she did not see him kiss her, but R6 and R12 stated he did. V10 stated, this happened close to the end of the second shift so after 9:00 PM sometime. On 06/08/24 at 7:48 PM, V22 (Licensed Practical Nurse/LPN) stated, she was working on the evening the incident happened between R8 and R12. V22 stated, she was working on the other hall when V12 (CNA) came and got her and told her R6 and R12 told her R8 kissed R12 twice on the lips. V22 stated, she went and talked to R12, and she confirmed R8 kissed her twice. She assessed R12 then left the room and called her supervisor V15 (Care Plan Coordinator/CPC). V15 told her she should call V1 (Administrator) and report it. V22 stated, she hung up with V15 and called V1 and reported that R8 had went into R12's room and had his arm around her and kissed her twice. V22 stated (after checking her notes) she reported this to V1 on the evening of 05/26/24. V22 stated they removed R8 from the room and redirected him back to his room, but she does not know if he understood why, because R8 does not speak English. Facility abuse policy, dated 2022, documents the following: the facility's residents have the right to be free from abuse, neglect, misappropriation of their property and exploitation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review the facility failed to report an allegation of sexual abuse to the State Agency for 1 of 1 resident (R12) in the sample of 13. Findings include: R12's Face sheet documents R12 has an admitted [DATE] with diagnoses including Paranoid Schizophrenia, Adjustment Disorder with Mixed Anxiety and Depression, Cerebral Infarction, Other Paralytic Syndrome following unspecified Cerebrovascular disease, Paralytic gait and Abnormalities of gait and mobility. R12's Minimum Data Sheet (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 15 indicating R12 is cognitively intact. R6's Face sheet documents R6 has an admitted [DATE] with diagnoses including Encephalopathy, Cerebral Infarction, Polyneuropathy, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non dominant side and Acquired absence of left leg below knee. R6's MDS dated [DATE] documents a BIMS score of 15 indicating resident is cognitively intact. R8's Face sheet documents an admitted [DATE] with diagnosis including Metabolic Encephalopathy, Essential Hypertension, Chronic Diastolic Heart Failure, Chronic Kidney Disease, Epilepsy and recurrent seizures and Cerebral Infarction. R8's MDS dated [DATE] section C is not completed therefore no BIMS score is documented. On 6/3/24 a handwritten document was provided by the V1 (Administrator) that documents interviews from R6 and R12 regarding and incident with R8. At the top of the document, it reads Interviews on 5/21/24. R6's interview: He (R8) followed (R12) to our room. (R12) went into the bathroom. He (R8) pulled the curtain and sat down on (R12's) rollator. He (R8) then got up and left the room. Later he (R8) came back in the room. He (R8) sat down on (R12's) bed. He (R8) pulled the curtain both times. We (R6 and R12) both told him to go. R12's interview: He (R8) followed me down here (room). I told him (R8) I had a roommate. He (R8) didn't stop. I went into the bathroom, and he (R8) sat down on my rollator. He (R8) came back to our room again after leaving the first time. He (R8) pulled the curtain and sat on the edge of my bed. He (R8) leaned over and kissed me on the lips two times. I motioned for him to leave. R6 yelled for staff. Staff led him away. On 06/03/24 at 1:38 PM, V1 stated, she does not have an investigation for R8 and R12 for abuse. She stated, she did an investigation for wandering for R8. V1 stated, R12 and R6 stated, that R8 kissed R12 twice, during the wandering incident but it was determined the incident was a wandering event not a resident-to-resident sexual abuse or an inappropriate sexual behavior. On 06/05/24 at 10:40 AM, V1 stated, she does not have any other investigation for the incident between R12 and R8 besides the one she gave on 06/03/24. V1 stated, she did not report this incident to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy dated 2022 titled, Residents Right To Freedom from Abuse, Neglect, and Exploitation Policy and Procedure documents in part: .The Facility will increase enforcement action, including, but not limited to: . B. Reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review the facility failed to identify an allegation of sexual abuse and then failed to complete a thorough investigation for an allegation of sexual abuse for 1 (R12) of 1 residents in a sample of 13. Finding include: R12's Face sheet documents R12 has an admitted [DATE] with diagnoses including Paranoid Schizophrenia, Adjustment Disorder with Mixed Anxiety and Depression, Cerebral Infarction, Other Paralytic Syndrome following unspecified Cerebrovascular disease, Paralytic gait and Abnormalities of gait and mobility. R12's Minimum Data Sheet (MDS) dated [DATE] documents a Brief Interview of Mental Status (BIMS) score of 15 indicating R12 is cognitively intact. R6's Face sheet documents R6 has an admitted [DATE] with diagnoses including Encephalopathy, Cerebral Infarction, Polyneuropathy, Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non dominant side and Acquired absence of left leg below knee. R6's MDS dated [DATE] documents a BIMS score of 15 indicating resident is cognitively intact. R8's Face sheet documents an admitted [DATE] with diagnoses including Metabolic Encephalopathy, Essential Hypertension, Chronic Diastolic Heart Failure, Chronic Kidney Disease, Epilepsy and recurrent seizures and Cerebral Infarction. R8's MDS dated [DATE] section C is not completed therefore no BIMS score is documented. On 06/03/24 at 1:17 PM, R6 stated she does not think it is right that R8 came down to R6 and R12's room and put his arm around R12 and kissed her and nothing has been done about it. R8 came down to their room and sat next to R12, put his arm around her and kissed R12 twice. R6 stated, she told him to leave, but he doesn't understand English. They told V10 (Certified Nurse Aide/CNA) and V12 (CNA) and nothing has been done about it. R8 came back down to their room a couple times, she tried to shoo him away and he came back down, and she threw a shoe at him to keep him from coming in the room. R6 stated, her and R12 told V1 (Administrator) on 05/28/24 and then saw him rubbing a staff members arm and another staff's back, she doesn't feel that is helping when he doesn't understand. R12 is uncomfortable and more nervous about going to activities now. On 06/03/24 at 1:19 PM, R12 stated R8 came down to her room on Memorial Day weekend (05/25/24 - 05/27/24) closed the curtain between her and R6, sat on the bed next to her, put his arm around her and kissed her twice on the lips. R12 stated she told him to leave but he doesn't understand English. R12 stated R6 yelled for staff to help, and they took him out of the room. They told the CNAs (V10 and V12) they did not want him in their room. R12 stated, it scares her when he is down in their room, and she does not want him in there. R12 stated, she does not want R8 to touch or kiss her. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/24 a handwritten document was provided by the V1 (Administrator) that documents interviews from R6 and R12 regarding and incident with R8. At the top of the document it reads Interviews on 5/21/24. R6's interview: He (R8) followed (R12) to our room. (R12) went into the bathroom. He (R8) pulled the curtain and sat down on (R12's) rollator. He (R8) then got up and left the room. Later he (R8) came back in the room. He (R8) sat down on (R12's) bed. He (R8) pulled the curtain both times. We (R6 and R12) both told him to go. R12's interview: He (R8) followed me down here (room). I told him (R8) I had a roommate. He (R8) didn't stop. I went into the bathroom, and he (R8) sat down on my rollator. He (R8) came back to our room again after leaving the first time. He (R8) pulled the curtain and sat on the edge of my bed. He (R8) leaned over and kissed me on the lips two times. I motioned for him to leave. R6 yelled for staff. Staff led him away. On 06/03/24 at 1:38 PM, V1 (Administrator) stated she does not have an investigation for R8 and R12 for abuse. She stated, she did an investigation for wandering for R8. V1 stated, R12 and R6 stated, that R8 kissed R12 twice, during the wandering incident but it was determined the incident was a wandering event not a resident-to-resident sexual abuse or an inappropriate sexual behavior. On 06/04/24 at 2:10 PM, V12 (CNA) stated she was present for the incident between R12 and R8. V12 stated, we (V12 and V10 (CNA)) heard R6 yelling for help, we walked in and R8 was sitting on the bed next to R12 and had his arm around R12, they redirected R8 out of the room and back down the hall. V12 stated, she didn't see anything but R6 told her R8 kissed R12. V12 stated, he went back down there one more time that night about 30 minutes later and a couple times since then that she knows of. They just redirect him back to his room. V12 stated, she does not know if R8 understands them, but he will go with them. They will usually point to things or make motions to things if they are figuring out what he wants, he doesn't speak English. V12 stated, she reported this incident to V22 (Licensed Practical Nurse (LPN)) that evening right after the incident. On 06/06/24 at 2:20 PM, V10 (CNA) stated she was present the evening of the incident with R12 and R8. V10 stated, her and V12 (CNA) were in the room across from R12's room when they heard R6 yell. R8 had his arm around R12 but she did not see him kiss her, but R6 and R12 stated he did. V10 stated, this happened close to the end of the second shift so after 9:00 PM sometime. On 06/08/24 at 7:48 PM, V22 (Licensed Practical Nurse/LPN) stated, she was working on the evening the incident happened between R8 and R12. V22 stated, she was working on the other hall when V12 (CNA) came and got her and told her R6 and R12 told her R8 kissed R12 twice on the lips. V22 stated, she went and talked to R12, and she confirmed R8 kissed her twice. She assessed R12 then left the room and called her supervisor V15 (Care Plan Coordinator/CPC). V15 told her she should call V1 (Administrator) and report it. V22 stated, she hung up with V15 and called V1 and reported that R8 had went into R12's room and had his arm around her and kissed her twice. V22 stated (after checking her notes) she reported this to V1 on the evening of 05/26/24. V22 stated they removed R8 from the room and redirected him back to his room, but she does not know if he understood why, because R8 does not speak English. On 06/05/24 at 10:40 AM, V1 (Administrator) stated, she does not have any other investigation information other than the two interviews from R6 and R12 for the incident between R12 and R8 that she provided on 06/03/24. V1 verified that she wrote the wrong date on the investigation with R6 and R12 and it was not 5/21/24. (continued on next page)

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Carmi Manor Rehab & Nrsg Ctr	615 West Webb Street Carmi, IL 62821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy dated 2022 titled, Residents Right To Freedom from Abuse, Neglect, and Exploitation Policy and Procedure documents in part: Procedure: III. The Facility shall review altercations from resident to resident as a potential situation of abuse. A Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to: C. Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing; and e. Wandering into other's rooms/space. IV. When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: A. taking steps to prevent further potential abuse, B. Reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations. C. Conducting a thorough investigation of the alleged violation. XIII. Response: A. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility shall: b. Have evidence that all alleged violations are thoroughly investigated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146124	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carmi Manor Rehab & Nrsg Ctr	615 West Webb Street Carmi, IL 62821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41610 Based on interview and record review the facility failed to accurately assessment a resident for 1 (R8) of 1 resident in a sample of 13. Findings include: R8's Facesheet documents R8 was admitted to the facility on [DATE]. R8's MDS dated [DATE] section C - Cognitive patterns contains only dashes for the complete section. Section D - Mood contains only dashes except for D0700 Social Isolation which designates an answer of 8 - resident unable to respond. and section E - Behavior contains only dashes with the exception of E0100 Potential Indicators of Psychosis which designates none of the above, indicating no hallucinations or delusions. On 06/06/24 at 10:46 AM, V21 (Minimum Data Set Coordinator/MDS) stated she does not do sections C, D, E or Q on the MDS. V21 stated that V3 (Social Services Director) does those sections. On 06/06/24 at 12:45 PM, V3 stated R8's MDS (Minimum Data Set) only has dashes in section C, D, and E because when she was doing the assessment with him she could not get any answers from him. They were unable to understand each other, because R8 speaks Haitian. V3 stated, she did not have his son interpret for her or try to help assist with the assessment. V3 stated, they did not utilize any of the healthcare hot line numbers to assist with the assessment either. She stated, she tried to use a picture board on her phone but he would not use it, he just wanted to play on her phone. V3 stated, she did answer the question in section E referring to hallucinations and delusions because the program that does the MDS would not let her complete the MDS without checking one of those boxes. V3 stated, if they have any questions or need to know something with R8 they usually contact his son and he will translate. The Resident Assessment Instrument (RAI) manual dated 10/2023 documents: Inability to make needs known and to engage in social interaction because of a language barrier can be very frustration and can lead to social isolation, depression, resident safety issues, and unmet needs. Language barriers can interfere with accurate assessments. When a resident needs or wants interpreter services the nursing home must ensure that an interpreter is available.