| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146124 | A. Building<br>B. Wing | 08/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Carmi Manor Rehab & Nrsg Ctr | 615 West Webb Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088<br><br>Based on interview and record review, the facility failed to ensure residents were free from resident-to-resident abuse for 3 (R1, R2, and R4) of 5 residents reviewed for abuse out of a sample of 13.<br><br>Findings include:<br><br>1. The facility's final Long-Term Care Facility .Serious Injury Incident and Communicable Disease Report dated 8/12/24 documented alleged abuse between R4 and R1 on 8/4/24. Both residents are marked as not interviewable. Under Detailed incident summary . the following is documented: This administrator was educated about an alleged incident between (R4) and (R1) on 8/4/24. Allegedly (R4) and (R1) were kissing and touching each other sexually . Investigation did not confirm incident. (R5) is not a credible witness due to a BIMS (equal to) 5 and often story tells, which is part of his care plan. When (R1) was interviewed by (V6 - Registered Nurse/RN) she indicated that, No, that didn't happen. Staff that were working did not see any interactions between (R4) and (R1). Interview of (R5), conducted by Administrator and Social Services Director, did not substantiate the allegation. (R5) could not recall the name of the male nor the time, place, or day . Based on the investigation findings, I was unable to substantiate the abuse allegation, therefore, the allegation is unfounded .<br><br>The facility's investigation of the 8/4/24 incident included a handwritten statement by V9 (Certified Nursing Assistant/CNA) that was dated 8/8/24 and documented in part . I (V9) come back from lunch break (R5) was standing up. I went over to him ask (sic) him what was wrong he said (R4) touch (sic) (R1) on her boobs on Sunday 11 AM 8/4/24 .<br><br>The facility's investigation of the 8/4/24 incident included a handwritten statement by V6 (RN) with date written 8/8/24 . at the top of the document but indicated 8/4/24 was the incident date. This statement documented in part Was alerted by staff (V9) that (R5) was standing up from (wheelchair) in (dining room). This nurse went to (dining room) . (R5) told this nurse that (R4) was kissing (and) touching (R1). This nurse went and asked (R1) about what (R5) had said he saw. (R1) states No that did not happen. This nurse did not see anything that (R5) alleged happened .<br><br>The facility's investigation of the 8/4/24 incident contained a handwritten interview of R5 that occurred on 8/8/24 documenting in part . (R1 and) 'the boy' were playing around together at the table. Asked when: 'thinks it was . day (R1) went to (hospital)' Both were enjoying it. (R1) was laughing. (R5) began to [NAME] off subject . This document was signed by V1 (Administrator) and V14 (Social Services).<br><br>(continued on next page) |



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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | R1's Face Sheet documented an admitted [DATE] with diagnoses including major depressive disorder, anxiety disorder, dysphagia, schizophrenia, and delirium due to known physiological condition. R1's Minimum Data Set (MDS) dated [DATE] documented no Brief Interview for Mental Status (BIMS) score due to R1 being rarely/ never understood.<br><br>R4's Face Sheet documented an admitted [DATE] with diagnoses including metabolic encephalopathy, epilepsy, and cerebral infarction. R4's MDS dated [DATE] documented no BIMS score due to R4 being rarely/ never understood.<br><br>R4's Care Plan documented a focus area of .I currently have an alteration in my behavior status (related to) agitation, wandering, inappropriate sexual behaviors . noting a date initiated of 5/24/24.<br><br>On 8/8/24 at 9:17 AM, V13 (Registered Nurse/RN) stated that R4 had inappropriate sexual behaviors. V13 said on one occasion R4 had tried to push V13 onto R4's bed and kiss her. V13 said on another occasion V13 was trying to administer R4's medications and R4 had grabbed V13 and tried to kiss V13.<br><br>On 8/8/24 at 1:43 PM, V9 (CNA) said she was walking back in from lunch when she saw R5 standing up from his wheelchair yelling. V9 said R5 was saying that R4 touched R1's breast and was kissing her. V9 said that she did not observe this herself, this is what R5 told V9 as she entered. V9 said that when she walked in, R1 and R4 were by each other. V9 said that she took R1 and moved her to the nurse's station. V9 said that she reported what happened to V6 (RN). V9 said she thought V6 reported it to V1 (Administrator).<br><br>On 8/8/24 at 1:59 PM, V6 (RN) stated she did know about R4 supposedly grabbing R1's breast and kissing her. V6 said the incident was hearsay from another resident and no staff witnessed it. V6 said she did not report it and knows that she is probably going to be in trouble, but I didn't witness it and no one else did either. V6 said she did not notify V1 (Administrator).<br><br>R5's Face Sheet documented an admitted [DATE] with diagnoses including Parkinson's Disease, dysphagia, bipolar disorder, and cerebral infarction. R5's MDS dated [DATE] documented a BIMS score of 5, indicating R5 severe cognitive impairment.<br><br>On 08/08/2024 at 2:20 PM, R5 presented as interviewable and stated that on Sunday (08/04/24), he was in the dining room and saw R4 start kissing R1. R5 stated that R1 was kissing R4 back. R5 said then R4 started to grab R1's breast and R1 started to grab R4's private area (penis). R5 said that he started yelling at them to stop. R5 stated I keep telling (R1) how disappointed in her I was and that she needed to stop it. R5 said that he saw V9 (CNA) coming in the doorway and R5 started yelling at V9. R5 said he told V9 what was going on and V9 took R1 away to the nurses station. R5 said he couldn't remember if R1 and R4 were still being inappropriate when V9 walked in the door. R5 said that he kept yelling at them to stop because it was inappropriate. During this interview, R5 appeared lucid, interviewable, alert and oriented to person, place, and time.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 2. The facility's final Long-Term Care Facility .Serious Injury Incident and Communicable Disease Report dated 8/12/24 documented a resident-to-resident altercation that occurred on 8/6/24. The residents involved were noted to be R4 and R2. R4 was noted to be the perpetrator, R2 was noted to be the victim, and both are marked as not interviewable. Under Detailed incident summary . the following is documented This administrator was advised that an alleged physical altercation occurred between (R2) and (R4) on 8/6/2024 . Investigation revealed that (V10/CNA) was placing trays in the window to be cleaned when she turned around and seen (R2) grab onto another resident's Geri chair armrest. When (R2) grabbed onto the armrest (R4) sat his hand on her arm. Prior to setting his hand on (R2's) arm, (R4) was sweeping the floor around and under the table of where (R2) was sitting. No other staff witnessed the interaction and neither of the residents are interviewable. (V12 - Licensed Practical Nurse/LPN) was called to the area by (V10), who then left. (V12) separated the residents but did not witness the incident. (V12) observed (R4) with a broom in one hand and a dustpan in the other hand . Based on the investigation, it was determined that (R4) was trying to remove (R2's) hand from the Geri chair in order to be able to move her wheelchair to clean underneath it. (R4) did not purposely or intentionally wish to cause harm to (R2). Therefore, allegation of abuse was not substantiated.<br><br>The facility's investigation of the 8/6/24 incident between R2 and R4 included a written statement from V10 (CNA) documenting in part .On Monday (sic) 8/6/24 I came from the window from putting a tray up. I looked up and saw (R4) try to move (R2) from the table and (R2) grabbed (another resident's) Geri chair and (R4) smacked (R2's) arm and I yelled for (V12) to come to the dining room, and (V12) separated (R2) and (R4) .<br><br>The facility's investigation of the 8/6/24 incident also included a written statement from V12 (LPN) documenting in part .(V10/CNA) stated to this nurse that (R4) slapped (R2) on arm. This nurse immediately removed (R2) from area, assessed, (and) observed (no) redness, swelling on arm. (R2) was not in any distress. This nurse then told (V10) to call (V1/Administrator) as she is the abuse coordinator. When this nurse entered dining room (R4) had broom in one hand and dustpan in the other sweeping floor. Neither (R4) nor (R2) had any (signs or symptoms) of distress .<br><br>R2's Face Sheet documented an admitted [DATE] with diagnoses including need for assistance with personal care, dysphagia, muscle wasting, lack of coordination, schizophrenia, cognitive communication deficit. R2's MDS dated [DATE] documented no BIMS score due to R2 being rarely/ never understood.<br><br>R4's Face Sheet documented an admitted [DATE] with diagnoses including metabolic encephalopathy, epilepsy, cerebral infarction. R4's MDS dated [DATE] documented no BIMS score due to R4 being rarely/ never understood.<br><br>On 8/8/24 at 1:50 PM, V10 (CNA) stated that on 8/6/24, V10 was walking through the dining room at the end of her shift to leave the facility and saw R2 sitting in a wheelchair at one of the dining tables. V10 said R4 came around the table and tried to move R2. V10 said R2 did not want to move and grabbed the arm rest of another resident's chair. V10 said when R2 grabbed the other resident's chair R4 slapped R2's arm. V10 said V10 yelled for V12 (LPN). V10 said V12 intervened and separated R2 and R4. V10 said she did not report the incident to V1 (Administrator) because she thought V12 would report the incident to V1.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 8/9/24 at 9:59 AM, V12 (LPN) said she was working on 8/6/24. V12 said V10 had reported to V12 that R4 had hit R2 in the dining room. V12 said she assessed R2 and did not find any injury. V12 said R2 was not interviewable and appeared to be unharmed. V12 said she did not report the incident to V1. V12 said it was V10's responsibility to report the incident because V10 was the staff that witnessed the incident.<br><br>The facility's undated Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure documented in part . The facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy . 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 other, which include, but are not limited to . b. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/ shoving, biting, spitting, threatening gestures, throwing objects . c. Sexually aggressive behavior such as saying sexual things, inappropriate touching/ grabbing . B. Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the Facility will take steps to ensure that the resident is protected from abuse. These steps shall include evaluating whether the resident has the capacity to consent to sexual activity . |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43088<br><br>Based on interview and record review, the facility failed to ensure allegations of resident-to-resident abuse were reported in a timely manner to the administrator of the facility and to other officials including the State Agency for 3 (R1, R2 and R4) of 5 residents reviewed for abuse out of a sample of 13.<br><br>Findings include:<br><br>1. R2's Face Sheet documented an admitted [DATE] with diagnoses including: need for assistance with personal care, dysphagia, muscle wasting, lack of coordination, schizophrenia, cognitive communication deficit. R2's Minimum Data Set (MDS) dated [DATE] documented no Brief Interview for Mental Status (BIMS) score due to R2 being rarely/ never understood.<br><br>R4's Face Sheet documented an admitted [DATE] with diagnoses including metabolic encephalopathy, epilepsy, cerebral infarction. R4's 7/14/24 MDS documented no BIMS score due to R4 being rarely/ never understood.<br><br>On 8/8/24 at 1:50 PM, V10 (Certified Nursing Assistant/ CNA) stated that on 8/6/24 V10 was walking through the dining room at the end of her shift to leave the facility and saw R2 sitting in a wheelchair at one the dining tables. V10 said R4 came around the table and tried to move R2. V10 said R2 did not want to move and grabbed the arm rest of another resident's chair. V10 said when R2 grabbed the other resident's chair R4 slapped R2's arm. V10 said V10 yelled for V12 (Licensed Practical Nurse/LPN). V10 said V12 intervened and separated R2 and R4. V10 said she did not report the incident to V1 (Administrator) because she thought V12 would report the incident to V1.<br><br>On 8/8/24 at 2:22 PM, this surveyor inquired with V1 about the alleged incident of resident-to-resident abuse that occurred between R4 and R2 on 8/6/24. V1 stated she was unaware and would open an investigation immediately.<br><br>On 8/9/24 at 9:59 AM, V12 (LPN) stated she was working on 8/6/24. V12 said V10 had reported to V12 that R4 had hit R2 in the dining room. V12 said she assessed R2 and did not find any injury. V12 said R2 was not interviewable and appeared to be unharmed. V12 said she did not report the incident to V1. V12 said it was V10's responsibility to report the incident because V10 was the staff that witnessed the incident.<br><br>On 8/9/24 at 11:09 AM, V1 said if any staff witness a resident-to-resident altercation they should notify me immediately. V1 said due to V10 witnessing the 8/6/24 incident V10 should have notified V1. V1 said she was not made aware of the 8/6/24 incident until the surveyor reported it on 8/8/24. V1 said V10 had been terminated due to not following the facility policy on reporting resident to resident incidents to V1 immediately.<br><br>The facility's initial Long-Term Care Facility .Serious Injury Incident and Communicable Disease Report documented an incident date of 8/6/24 and a report date of 8/8/24.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. R1's Face Sheet documented an admitted [DATE] with diagnoses including: major depressive disorder, anxiety disorder, dysphagia, schizophrenia, delirium due to known physiological condition. R1's Minimum Data Set (MDS) dated [DATE] documented no Brief Interview for Mental Status (BIMS) score due to R1 being rarely/ never understood.<br><br>R4's Face Sheet documented an admitted [DATE] with diagnoses including metabolic encephalopathy, epilepsy, cerebral infarction. R4's 7/14/24 MDS documented no BIMS score due to R4 being rarely/ never understood.<br><br>On 8/8/24 at 1:43 PM, V9 (CNA) said on 8/4/24 she was walking back in from lunch when she saw R5 standing up from his wheelchair yelling. V9 said R5 was saying that R4 touched R1's breast and was kissing her. V9 said that she did not observe this for herself, this is what R5 told V9. V9 said that when she walked in, R1 and R4 were by each other. V9 said that she took R1 and moved her to the nurse's station. V9 said that she reported what happened to V6 (Registered Nurse/RN). V9 said she thought V6 reported it to V1 (Administrator).<br><br>On 8/8/24 at 1:59 PM, V6 (RN) stated she did know about R4 supposedly grabbing R1's breast and kissing her. V6 said the incident was hearsay from another resident and no staff witnessed it. V6 said she did not report it and knows that she is probably going to be in trouble, but I didn't witness it and no one else did either. V6 said she did not notify V1 (Administrator).<br><br>On 8/8/24 at 2:22 PM, , this surveyor inquired with V1 about the alleged incident of resident to resident abuse that occurred between R4 and R1 on 8/4/24. V1 stated she was unaware and would open an investigation immediately.<br><br>On 8/9/24 at 11:09 AM, V1 said if any staff receive an allegation of resident-to-resident sexual abuse they should notify me immediately. V1 said she was not made aware of the 8/4/24 incident until the surveyor reported it on 8/8/24.<br><br>The facility's initial Long-Term Care Facility .Serious Injury Incident and Communicable Disease Report documented an incident date of 8/4/24 and a report date of 8/8/24.<br><br>The facility's undated Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure documented in part . In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility shall . a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to this policy . |