

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Carmi Manor Rehab & Nrsng Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43088</p> <p>Based on observation, interview and record review, the facility failed to implement current behavior interventions for a resident with inappropriate sexual behaviors and failed to re-assess and implement progressive individualized interventions for increased occurrences of unwanted sexual behaviors for 1 (R1) of 3 residents reviewed for behavioral health in the sample of 5.</p> <p>Findings include:</p> <p>R1's face sheet documented an admitted [DATE] with diagnoses including metabolic encephalopathy, epilepsy, cerebral infarction. R1's 7/14/24 Minimum Data Set, dated dated [DATE] documented no Brief Interview for Mental Status (BIMS) score due to R1 being rarely/ never understood.</p> <p>A handwritten document was provided by the V1 (Administrator) that documents interviews from R9 and R8 regarding an incident with R1. At the top of the document, it reads Interviews on 5/21/24. R9's interview: He (R1) followed (R8) to our room. (R8) went into the bathroom. He (R1) pulled the curtain and sat down on (R8's) rollator. He (R1) then got up and left the room. Later he (R1) came back in the room. He (R1) sat down on (R8's) bed. He (R1) pulled the curtain both times. We (R9 and R8) both told him to go. R8's interview: He (R1) followed me down here (room). I told him (R1) I had a roommate. He (R1) didn't stop. I went into the bathroom, and he (R1) sat down on my rollator. He (R1) came back to our room again after leaving the first time. He (R1) pulled the curtain and sat on the edge of my bed. He (R1) leaned over and kissed me on the lips two times. I motioned for him to leave. R9 yelled for staff. Staff led him away.</p> <p>R1's care plan documented a focus area initiated on 5/24/24 . I currently have an alteration in my behavior status (related to) agitation, wandering, inappropriate sexual behaviors . and listed the following interventions/ tasks: 5/24/24 my behaviors will be monitored every shift and documented, 5/24/24 Intervene as necessary to protect (R1's) rights and safety of others. Approach/ speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed, 5/24/24 Minimize potential for the disruptive behaviors by offering tasks which divert attention such as encourage activity participation and monitored outdoor time, 5/24/24 Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behaviors and potential causes, 5/24/24 Praise any indication of (R1's) progress/ improvement in behavior, 5/30/24 Behavior - Inappropriate Sexual Behavior, 7/30/24 15-minute checks.</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 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility incident report regarding R1 and R7 dated 8/12/24 documented alleged abuse between R1 and R7 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 (R1) and (R7) on 8/4/24. Allegedly (R1) and (R7) were kissing and touching each other sexually .</p> <p>R1's care plan documented no new intervention for sexually inappropriate behaviors since 7/30/24.</p> <p>On 8/21/24 at 2:37 PM, V13 (Certified Nursing Assistant/ CNA) stated she had heard R1 had tried to be sexually inappropriate with R6's great-granddaughter. V13 stated she had not witnessed the incident but had heard other staff talking about it. V13 stated she was not sure when this incident happened.</p> <p>On 8/21/24 at 2:45 PM, V12 (Family Member) stated a couple weeks ago she and her [AGE] year-old granddaughter were in the facility visiting with R6. V12 stated her granddaughter had reported to her that a man in the facility's dining room had tried to touch her chest. V12 stated she did not witness the incident and was unsure if any staff witnessed the incident. V12 stated she had reported the incident to a staff member she thought was V14 (Licensed Practical Nurse/ LPN) but was not certain. V12 stated she was not sure what day the incident took place.</p> <p>On 8/22/24 at 10:32 AM, V14 (LPN) stated V12 had reported to V15 (CNA) that R1 had tried to inappropriately touch V12's granddaughter. V14 stated V15 had reported the incident to V14. V14 stated she was not sure what date or time the incident took place. V14 stated V15 had notified V1 (Administrator) via telephone after the incident occurred.</p> <p>On 8/22/24 at 10:45 AM, attempted to contact V15 via telephone. V15 did not answer and did not have a voicemail set up.</p> <p>On 8/22/24 at 10:45 AM, V1 stated V15 was employed at the facility on an as needed basis. V1 stated she would try to contact V15 to make V15 available for an interview.</p> <p>On 8/21/24 at 3:38 PM, V1 stated she was not aware of any incident involving R1 and V12's granddaughter.</p> <p>On 8/21/24 at 2:15 PM, V3 (Assistant Director of Nursing and Care Plan Coordinator) stated she was not aware of the incident between R1 and V12's granddaughter.</p> <p>On 8/20/24 at 1:06 PM, V6 (Housekeeper) stated she had two incidents with R1 being sexually inappropriate with her. V6 stated on one occasion she was walking through the dining room when R1 had come up to her and grabbed her breasts. V6 stated on another occasion R1 was outside and V6 was trying to assist another staff to get R1 back into the building when R1 grabbed her around the waist and refused to let go requiring another staff member to intervene. V6 stated she had reported both instances to V1 (Administrator). V6 stated she had not received any education on how to respond to R1 when R1 had sexually inappropriate behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/20/24 at 1:48 PM, V3 (Assistant Director of Nursing/ ADON and Care Plan Coordinator) stated she had never seen R1 have any inappropriate sexual behaviors. V3 stated R1 would rub staff's backs but V3 did not feel like this was a sexually inappropriate behavior. V3 stated a sexually inappropriate behavior was open to interpretation by staff. V3 stated if a staff member saw R1 having a sexually inappropriate behavior they should try to redirect R1 by assisting R1 to go for a walk outside or by offering a drink or snack.</p> <p>On 8/20/24 at 12:15 PM, V5 (Certified Nursing Assistant/ CNA) stated she had never been educated on what a sexually inappropriate behavior was. V5 stated what she would consider as a sexually inappropriate behavior might be different than what someone else would consider a sexually inappropriate behavior. V5 stated if R1 was to exhibit a sexually inappropriate behavior she would take him outside. V5 stated sometimes R1 was able to be redirected and sometimes R1 was not able to be redirected due to R1 not speaking English. V5 stated she had never received any education on what staff should do if R1 exhibits a sexually inappropriate behavior.</p> <p>On 8/20/24 at 12:09 PM, V7 (CNA) stated a sexually inappropriate behavior would be touching someone's breasts or rubbing someone's back if they don't want it. V7 stated she had not received any education on how to react to R1 if she saw R1 having a sexually inappropriate behavior. V7 stated she was not sure what activities she was supposed to redirect R1 with.</p> <p>On 8/20/24 at 1:00 PM, V4 (Registered Nurse/ RN) stated earlier in her shift R1 had tried to kiss a staff member. V4 stated she did not think trying to kiss a staff member was appropriate behavior, but V4 had never seen anything defining what a sexually inappropriate behavior was. V4 stated she was not sure if all the staff reacted to R1's sexually inappropriate behaviors the same way.</p> <p>On 8/21/24 at 9:25 AM, R1 was lying in bed in his room resting with the door closed. Continuous observation of R1's closed door from 9:25 AM until 10:25 AM was completed and no staff checked on R1.</p> <p>On 8/21/24 at 10:12 AM, no staff could be seen in the hallways, nurse's station, or dining room. 7 residents were sitting in the dining room with 4 of the residents being female.</p> <p>On 8/21/24 at 10:25 AM, V9 (Certified Nursing Assistant/ CNA) and V10 (CNA) were asked if they knew where R1 was located in the facility, and both responded they thought R1 was in his room but were not sure.</p> <p>On 8/21/24 at 1:40 PM, V11 (Licensed Practical Nurse/ LPN) stated there were 4 CNAs working in the facility from 6:00 AM until 2:00 PM. V11 stated the CNAs had designated residents for charting purposes but were not assigned as responsible for any specific resident's care. V11 stated the CNAs worked together in caring for all residents. V11 stated she was not sure if any CNA was assigned to complete R1's 15-minute checks. V11 stated there should be a form at the nurse's station documenting R1's 15-minute checks but V11 was unable to locate any form. V11 stated R1 was supposed to be checked on every 15 minutes due to R1's behaviors of wandering and history of being sexually inappropriate with female residents.</p> <p>On 8/20/24 at 2:29 PM, V2 (Director of Nursing/ DON) stated she expected staff to check on R1 every 15 minutes due to R1's behaviors.</p> <p>(continued on next page)</p>		

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F 0740  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	The facility's revised November 6, 2019, Care Plans Policy & Procedure documented in part .Our facility's Care Planning/ Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .		