

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Manor Court of Carbondale		STREET ADDRESS, CITY, STATE, ZIP CODE 2940 W Westridge Place Carbondale, IL 62901	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to ensure a call light was within reach for 1 of 3 residents (R2) reviewed for accommodation of needs in a sample of 6. Findings include: R2's document titled Face Sheet documents admission date of 5/12/2022 and includes Chronic Atrial Fibrillation, Osteoarthritis, Anemia, Essential Hypertension, History of Transient Ischemic Attack (TIA), and Sleep Apnea. R2's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 15 suggesting R2's cognition is intact. R2's MDS documents R2 is dependent on staff for, sit to stand, chair/bed-chair transfer, and toilet transfer and that R2 requires substantial/maximal assistance with lying to sitting on side of bed and sitting to lying. R2's Care Plan documents R2 is at risk for falls. Interventions are to instruct residents to call for assistance before getting out of bed or transferring. Orientate residents to room, surrounding areas, and use of call light system. On 2/4/2026 at 11:05AM, R2 was observed sitting in the back of her room in her wheelchair. R2 did not have call light within reach. R2's call light was noted to be tied to left side of bed on the handrail. R2 was noted to be several feet from call light. On 2/4/2025 at 12:27PM, R2 was observed sitting in the same spot in her room and did not have a call light within reach. On 2/4/2026 at 12:55PM, V3 Certified Nurse Assistant (CNA) was asked if she cared for R2 and V3 stated yes. V3 showed where R2 was sitting in her room and V3 stated she sits there most of the time. V3 was asked why she sat so far away from the call light, V3 stated well she pushes herself back there. V3 was not sure if R2 could move up closer to the call light but knows she can push herself back. On 2/4/2026 at 1:10PM V4 (CNA) stated R2 does sit in that spot and the call light will not reach over there but R2 pushes herself backward out of reach of the call light. On 2/4/2026 at 2:10PM, V2 Director of Nursing (DON) stated R2 does sit in that spot in her room but wasn't sure if the call light would reach because they do have long cords on the call lights. V2 stated, I do know that R2 pushes herself there. V2 was asked if this was a concern with R2 not having access to the call light for long periods of time and V2 stated he would check out the situation and must make adjustments. On 2/5/2026 at 12:25PM, R2 was noted to be sitting up in wheelchair eating lunch. R2 was sitting again in the back of the room and call light was 8.5 feet away from R2. Call light was tied to the left side rail which is the side rail farthest away from R2. Call light was untied and stretched as far as it would go towards R2 and measured 8.5 feet away from R2. R2 was asked if she pushed herself in her wheelchair to the back of the room, R2 stated yes I can push myself back. R2 was asked why she chose to sit to the back of the room where she is without reach of her call light. R2 was asked if she could move herself back up to use her call light and R2 stated well that is where I have trouble, the shoes I wear are slick on the floor and I can't hardly go forward. R2 stated if I need help, I will try to get up to the call light and hope that I can. R2 stated sometimes I call my daughter or try to make my way to the doorway and start yelling at the staff for help. On 2/6/2026 at 11:31AM, V15 (R2's Daughter) was asked if she had seen R2 sitting in (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 146171	Facility ID: 146171 If continuation sheet Page 1 of 10

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the back of her room and V15 stated yes most of the time. V15 stated she visits weekly. V15 stated R2 likes to sit by the window. V15 was asked if R2 was able to propel herself forward in the wheelchair and V15 stated that is a struggle for R2, and she takes a long time to get very far. V15 was asked if R2 ever calls her if she needs anything when she can't reach her call light, V15 stated yes she does quiet often. V15 stated she didn't realize the call light would not reach back there to where R2 sits and stated that it is concerning her and is a risk for several things to happen. Policy titled Resident Rights dated revision date of 11/28/2017 contains documentation of F558-Reasonable Accommodation of Needs/Preferences: the right to reside and receive services in the facility with reasonable accommodation of residents' needs and preference except when to do so would endanger the health or safety of the resident or other residents.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow physicians' orders, provide interventions and monitor residents at risk for pressure ulcers for 3 or 3 residents (R1, R2 and R6) reviewed for pressure ulcers in the sample of 6. This failure resulted in R1 acquiring 3 stage II pressure ulcers. The findings include:1.R1's Face Sheet documents an admission date of 6/23/2022 and includes diagnoses of Chronic Pulmonary Edema, Type 2 Diabetes Mellitus, Local Infection of the skin and Subcutaneous Tissue, Thyroiditis, Hyperlipidemia, Hypertension, Insomnia, and Chronic Atrial Fibrillation. R1's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 15 suggesting R1's cognition is intact. Section GG-Functional Abilities documents R1 requires Substantial/Maximal assistance with toileting hygiene, rolling left to right (the ability to roll from lying on back to left and right side, and then return to lying on back on the bed). R1 requires partial/moderate assistance with sitting to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, tub/shower transfer. Section H- Bladder and Bowel documents R1 is occasionally incontinent of urine, and bowel. Section M- Skin Conditions documents R1 is at risk for pressure sores. Document shows R1 has a pressure reducing device for chair and bed.R1's care plan documents he is at increased risk for pressure ulcers and skin breakdown related to decreased mobility, generalized muscle weakness, history of pressure ulcers and diabetes. R1 prefers to stay in bed most of the day. R1 currently has boggy heels, shearing to his buttocks, MASD (Moisture Associated Skin Disorder) to the underside of penis, shearing to his lower abdominal fold, and an open area to the underside of his left nipple. Problem starts on the date 6/27/2022, and last revision on 2/3/2026. Interventions are to assess nails, treatment to bilateral heels, treatment to shearing of lower abdominal fold as ordered, treatment to shearing buttocks as ordered, treatment to peri area as ordered, comfort glide, low air loss mattress, serve high protein supplement per physician orders, encourage to protect upper extremities during therapy as tolerated. Assist resident with turning and repositioning, provide incontinent care after each incontinent episode, and side rails/enablers to assist with turning and positioning. R1's Physician Orders documents on 8/27/2024-open ended for apply skin prep to bilateral heels twice daily. On 9/10/2025-open ended document shows order for cleanse buttock region gently with Normal Saline or wound cleanser. Pat dry. Apply Triad cream to bilateral buttocks and coccyx to shearing twice a day. Apply non adherent dressing as needed for bleeding. Antifungal (Miconazole nitrate) powder 2% twice a day, apply antifungal powder to area (MASD) and shearing to scrotum and penis area, order date 10/8/2024-open ended. Off- loading boots as tolerated twice a day 6:00AM-6:00PM and 6:00PM-6:00AM, dated 9/27/2024-open ended.R1's Braden Scale for Predicting Pressure Sore Risk documents on 12/17/2025 a score of 18.0 indicating R1 is At Risk for predicting pressure sore. R1's Braden Scale dated 1/8/2026 documents a score of 17 At Risk. R1's Braden Scale dated 1/29/2026 documents a score of 15 At Risk. On 2/4/2026 at 10:45AM, R1 was observed sitting up in recliner with a pressure relieving cushion in the chair. Call light was within reach. R1 was watching television. R1 was alert and oriented and stated he was waiting for therapy to get him to go to the gym. R1 stated he thinks his care is quite good. R1 stated he hasn't been getting his showers due to the sores he has on his butt. R1 stated, I got sores because I sit or lay around too much. R1 stated he had the air mattress on his bed for a long time even before he got the sores. R1 stated he also has had a pad in his recliner for a long time as well. R1 was asked if he was able to reposition himself while in the recliner and R1 stated, no and I can't reposition myself in the bed either. R1 was asked if the staff comes in to reposition him while he is in the chair and R1 stated, 'No. R1 was asked if they reposition him</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>while he is in bed and R1 stated usually if I am in the bed during the day which I am sometimes, they will come and help reposition me but during the night they only come and help me reposition if I ask and sometimes that is just a couple of times through the night if I wake up. Offloading boots were not in place at this time. R1 refused to let this surveyor observe his bilateral heels. On 2/5/2026 at 10:50AM Observation of peri care was performed on R1 by V4 (Certified Nurse Aide/CNA) and V11 (CNA). During peri care V4 pulled back the foreskin of the penis and R1's penis was noted to be very red with a white like paste which was difficult to remove during cleaning. During peri care noted R1's buttocks did not have a dressing to areas on buttocks. R1 had 2 noted open areas to the right buttocks and 1 open area the intergluteal cleft. Areas were cleaned during peri care. R1's buttock was noted to be red with flaky skin noted over a large part of the buttocks. Open areas to the buttocks were noted to be bleeding as blood was also noted on the pad that R1 was lying on. Offloading boots were not present at the time of this observation. On 2/5/2026 at 11:05AM, V12 Licensed Practical Nurse (LPN) and V13 (Registered Nurse/ RN) entered the room to do the treatments on R1. V12 was asked who measured the wounds, V12 stated there are 2 wound nurses that measure the wounds but when they are both off, she measures when the measurements are due. V12 was asked if she knew if the 3 open areas to R1's right buttocks had been measured and V12 stated she would have to check and see. All 3 open areas were noted to be Stage 2 areas with partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed of the wounds were pink/red with slight bleeding noted. R1 also had 1 open area (long slit) noted to the intergluteal cleft and 2 open areas to right buttocks (medial and lateral right buttocks). The left buttock was noted to have flaky skin on entire left buttocks. V12 cleansed open areas to R1's right buttocks with wound cleanser, areas were patted dry, then Triad ointment was applied to open areas and surrounding areas and covered with a foam border gauze. V12 had powder in a cup to apply to R1's penis but R1 stated he likes the ointment best. A tub of ointment was noted on R1's bedside table. V13 handed the tub to V12 with the tub label of Diaper Rash Cream and contained Zinc Oxide. V12 applied to R1's penis and groin area. R1 was noted to be on an air loss mattress. No skin prep application was observed for bilateral heels and offloading boots were not applied. The facility policy titled Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol revised 10/16/2024, documents under Sages of Pressure Injury Definitions a stage 2 pressure ulcer is Partial thickness loss of skin with exposed dermis presenting as a shallow open ulcer with a red/pink wound bed (without slough, eschar, or granulation tissue). May also present as an intact or open/ruptured serum filled blister. R1's Progress notes documents on 2/5/2026 at 10:04AM, V20 Nurse Practitioner (NP) updated on possible deterioration of buttocks wound. NP stated to retain current treatment orders, and she will assess tomorrow in person. Authored by V2 (Director of Nursing). R1's progress notes dated 2/5/2026 at 11:18 AM, V12 documented NP contacted to ask for treatment replacement for antifungal powder. Residents' family brought Diaper rash cream with Zinc in it for resident, he stated that it works better than the powder. NP ok with treatment change and with resident having access at bedside. On 2/5/2026 at 12:00PM reviewed document titled Facility Wound Summary Report dated 10/1/2025-2/4/2026. R1's wounds were not present on this wound report. On 2/5/2026 at 12:30PM, V2 was asked why R1's wounds were not on the Facility Wound Summary Report, V2 stated, I believe R1's wounds are shears so we don't measure those. V2 was asked how they monitor shears, V2 stated, we look at weekly skin notes. V2 was asked if it is acceptable to use over the counter ointments on skin issues without a physician's order, V2 stated no that is not acceptable. V2 was asked if they had a policy for turning and repositioning and V2 stated no. V2 was asked if there was documentation of R1's turn and repositioning and V2 stated no we do not document that, we just follow the</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>standard which is turn and reposition every 2 hours.R1's Weekly skin assessment dated [DATE] at 2:04AM documents 3) Bilateral shearing to buttock remains. No bleeding observed at this time. Cleansed and Triad applied per order. 2) Heels remain boggy bilaterally. Treatment in place at this time and administered. Authored by V19. R1's weekly skin assessment dated [DATE] at 12:11AM 1) Shearing to buttocks remains bilaterally. Mild bleeding noted. New dressings applied. Treatment continues. 2) Boggy heels bilaterally remain. Sure- Prep applied per treatment. Authored by V19 Licensed Practical Nurse (LPN).R1's weekly skin assessment dated [DATE] at 6:15PM (readmission Skin Assessment) 1) moderate shearing present to bilateral buttocks. No bleeding noted, no signs and symptoms of infection noted. Area cleansed and Zinc applied as ordered. 2) Bilateral heels boggy, sure prep applied as ordered. Authored by V18 RN. R1's documents titled Resident Progress Notes documents on 2/3/2026 at 6:22AM Weekly Skin Assessment 1) moderate shearing to bilateral buttocks. No bleeding and signs or symptoms of infection. Area cleansed. Zinc applied. 2) Bilateral heels boggy. Sure- Prep applied as ordered. Authored by V17 Registered Nurse (RN). R1's Progress Notes document that R1 was sent to the ER (Emergency Room) on 1/13/26 and R1 returned from the hospital on 1/28/26. was hospitalized from [DATE]-[DATE].R1's document titled Wound Management Detail Report date /time identified 2/5/2026 at 1:48PM R1's Right Lateral Buttocks, unspecified ulcer, measuring 0.4cm (Centimeter) L(Length) x 0.5 cm W (Width). Right Meidal Buttocks, date/time identified 2/5/206 at 1:47PM unspecified ulcer, measuring 0.4cm L x 0.5 cm W. Coccyx Intergluteal cleft, date/time identified 2/5/2026 at 1:43PM unspecified ulcer, measuring 2.5cm L x 0.4cm W with light exudate of serous drainage, tissue type epithelial. 2. R2's document titled Face Sheet documents admission date of 5/12/2022 and includes Chronic Atrial Fibrillation, Osteoarthritis, Anemia, Essential Hypertension, History of Transient Ischemic Attack (TIA), and Sleep Apnea.R2's Minimum Data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 15 suggesting R2's cognition is intact. Section GG -Functional Abilities documents R2 depends on staff for showers/baths, lower body dressing, putting on and taking off footwear, sit to stand, chair/bed-chair transfer, and toilet transfer. R2 requires substantial/maximal assistance with lying to sitting on side of bed and sitting to lying. R2 requires partial/moderate assistance with upper body dressing and roll left to right. Section H-Bladder and Bowel documents R2 is occasionally incontinent of bladder and bowel. Section M- Skin Condition documents R2 is at risk for developing pressure ulcers/injuries. R2 has pressure relieving devices for chair and bed.R2's care plan dated 5/12/2022, documents R2 is at increased risk for pressure ulcers and skin breakdown related to decreased mobility, chronic atrial fibrillation, osteoarthritis, history of stroke, anorexia, anemia, and incontinence. Interventions include applying skin prep to bilateral heels twice daily, off-loading boots in place as ordered, assisting in turning and repositioning, providing incontinence care after each episode.R2's Physician Order report dated 2/4/2026 documents orders for Apply skin prep to bilateral heels twice a day, order date of 10/9/2024. Ensure off-loading boots are in place to bilateral lower extremities as tolerated twice a day 6:00AM-6:00PM and 6:00PM-6:00AM, order date 10/28/2025.R2's Treatment Administration Record documents order for Ensure off-loading boots are in place to bilateral lower extremities as tolerated twice a day 6AM-6PM and 6PM-6AM. Reviewed 1/5/2026-2/4/2026 with several entries of refusal to wear boots.R2's Braden Scale for Predicting Pressure Sore Risk documents 6/23/2025 with score of 15.0= At Risk. On 8/4/2025 score of 14.0 = Moderate Risk, and 11/4/2025 score of 10 = At High Risk.Document titled Facility Wound Summary does not have R2 on the log for the bilateral boggy heels.R2's Resident Progress Notes documents 1/21/2026 at 6:36PM 1) bilateral boggy heels. Authored by V6. On 1/28/2026 at 6:13PM 1) bilateral heels remain boggy. Sure prep applied as ordered. No open areas noted. Continue to monitor. Authored by V21 LPN. On 2/4/2026 at</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>2:45PM 1) bilateral boggy heels, authored by V6 LPN. On 2/4/2026 at 11:05AM, R2 was observed sitting up in room in a wheelchair. R2 was alert and oriented. R2 had regular shoes on and feet resting on foot pedals of wheelchair. Offloading boots were not in place. R2 stated I am just relaxing here waiting for lunch. On 2/5/2026 at 6:17AM, Observed R2 did not have bilateral boots while in bed, bilateral heels were very red. R2 had no footwear on at the time of observation. On 2/5/2026 at 12:25PM, R2 was asked if she ever wore her boots on her feet. R2 laughed and stated, I may have had one boot on one time. R2 was asked if she refuses to wear the boots, R2 stated I believe I have only had 1 boot on 1 time; nobody ever offers or tries to put my boot on. R2 stated I can tell you where to find the boot, it is in my closet where it always stays. R2 stated I haven't worn that boot in a long time, nobody has tried to put it on and I sure can't put it on myself. R2's closet was checked and one blue pressure relieving boot was noted lying in the bottom of the closet. R2 was asked where the other boot was and R2 stated I have only ever seen 1 boot. On 2/5/2026 at 1:30PM, R2 was observed lying in bed. No boots were noted to R2's bilateral feet. V13 was sitting at the nurse's station and was asked to go to R2's room to assist with assessment of R2's heels. V13 went to R2's room V13 assessed both heels and stated, the left heel is really soft and boggy, and the right one is not so bad but is more boggy on the outer aspect of the heel, left heel is non-blanchable. Boots were not applied at this time after the assessment. V13 stated he had not seen boots on R2. On 2/5/2026 at 2:45PM, V2 was asked if he expects staff to apply offloading boots to residents with orders and are at risk for pressure ulcers, V2 stated, yes I do but sometimes they refuse to wear them. On 2/6/2026 at 11:31AM, V15 (R2's Daughter) was asked if she has ever seen boots (pressure relieving) on R2 and V15 stated she has never seen any type of boots on R2. V15 stated she was not aware that R1 was supposed to have special boots on. On 2/6/2026 at 12:55PM, V16 Physician was asked if he expected the staff to follow physician orders, V16 stated yes I do. V16 was asked if he feels that offloading boots prevent heel wounds and/or help the healing process of current heel wounds. V16 stated in theory yes, the boots do help prevent and enhance healing. V16 stated he feels like the offloading boots are automatically accumulated on orders maybe for residents that meet the criteria for them. V16 stated he knows the facility has several residents that have orders for boots. V16 stated he was not aware of any residents not wearing their boots and he knows the facility has a lot of residents with orders for the boots. 3. R6's document titled Face Sheet documents an admission date of 10/7/2025 and includes diagnoses of Acute Cystitis without Hematuria, Dementia, Type Diabetes Mellitus, Urinary Retention, Generalized Anxiety, Epilepsy, Major Depressive Disorder, and Mixed Hyperlipidemia. R6's Minimum data Set (MDS) dated [DATE] includes a Brief Interview for Mental Status (BIMS) score of 13 suggesting R6's cognition is intact. Section GG -Functional Abilities documents R6 requires Partial/moderate assistance with toileting hygiene, lower body dressing, rolling left to right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), lying on the side of the bed, tub/shower transfer. R6 requires substantial assistance with shower/bathing, putting on/taking off footwear, sit to stand, chair/bed-to-chair transfers, toilet transfers. Section H-Bladder and Bowel show R6 is occasionally incontinent of bowel and R6 has an indwelling catheter for urination. Section M-Skin Conditions documents R6 is at risk of developing pressure ulcers/injuries. Document shows R6 has 1 unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar, and 1 unstageable deep tissue injury. R6's care plan documents R6 is at increased risk for pressure ulcers related to decreased mobility, generalized muscle weakness following recent illness and hospitalization, dementia, humerus fracture, diabetes, major depression disorder, and generalized anxiety disorder. R6 currently has a pressure injury to her left heel, edema to her left upper extremity, and a</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	<p>pressure injury to left buttocks. Problem start date was 10/7/2025. Approach includes: 12/26/2025 treatment to pressure injury of left buttocks, 10/27/2025 off-loading boot in place as tolerated, 10/17/2025 treatment to pressure injury to left heel as ordered, 10/7/2025 assist in turning and repositioning, 10/7/2025 pressure reducing device in wheelchair and bed. Physician Order Report dated 2/5/2026 shows orders for wounds as follows: Deep Tissue Injury (DTI) to buttocks; cleanse with Normal Saline or wound cleanser, pat dry, apply Zinc and border foam dressing daily, dated 1/2/2026. Left Heel, cleanse with wound cleanser and pat dry. Apply Medi honey to wound bed. Cover with gauze and ABD pad, wrap with gauze and secure with tape daily, dated 1/8/26. Offloading boots in place as tolerated twice a day 6:00AM-6:00PM and 6:00PM-6:00AM dated 10/28/2025. R6 Braden Scale for Predicting Pressure Sore Risk documents: 10/8/2025 score 22.0 Not at Risk, 10/21/2025= 17.0 At Risk, 10/31/2025=17.0 At Risk. Document titled Facility Wound Summary documents R6 has a Pressure Ulcer unstageable-slough and or eschar with date identified 10/22/2025 to left heel. Wound was not present upon admission, initial size as 2cm L x 4.8cm W, and current size 1.5cm L x 1.7cm W. On 2/4/2026 at 1:52AM, R6 was observed resting in bed. R6 stated she has a wound to her foot. R6 did not have an off-loading boot in place at the time of observation. R6 stated she gets help with turning and repositioning sometimes on nights, not always every 2 hours and she is up a lot in her wheelchair during the day. On 2/5/2026 at 1:50PM, R6 was resting in bed. R6 did not have a pressure-relieving boot on her left foot as ordered. On 2/5/2026 at 3:17PM, R6 was sitting up in wheelchair in the dining room. R6 was asked privately about her wounds that were documented to left buttocks and left heel. R6 was asked if she understood how she acquired these wounds and R6 stated, Yes I know, it is because I sit up in this wheelchair all day long some days. R6 was asked if she was repositioned in the wheelchair throughout the day and R6 stated, no not while I am in the wheelchair. R6 was noted to have a dressing to the left heel with gauze wrap noted. Left heel/foot was resting on the metal foot pedal. No offloading boot was noted. R6 was asked if she ever wore a big boot on her left foot or does staff apply boot and R6 stated, no. On 2/5/2026 at 3:45PM discussed with V2 the Facility Wound Summary. Discussed the summary had information of R6's wound to her left buttocks but does not show a recent measurement of the wound and the last measurement was on 12/26/2026. V2 stated well maybe it is healed. V2 was asked why there were still orders for treatment to the left buttocks on the Physician Order Sheet with a start date of 1/2/2026. On 2/5/2026 at 3:50PM R6 was taken to her bathroom with V13, and a CNA present and an assessment was done and there are no open areas to the left buttocks. V13 validated there were no open areas to R6's buttocks. On 2/5/2026 at 3:55PM, V2 was informed there were no open areas to R6's buttocks. V2 was asked why there would still be an active order for the treatment and V2 stated I am working with new young nurses, and they have a lot to learn. V2 was asked if he expects the nurse to follow physician orders and V2 stated yes. V2 was asked if he expects the staff to apply offloading boots on the residents with orders for the boots and V2 stated of course I do. On 2/10/2026 at 8:36AM, V22 Nurse Practitioner (NP/Wound clinic) returned call and stated she does see R6 in the clinic for wound care to the left heel. V22 stated R6 has never seen her off loading boot to her left heel and when she asks R6 why she doesn't have it on, R6 stated the staff says I don't need it anymore, so they do not put it on. V22 was asked if she felt like the off-loading boot is needed, V22 stated yes, it would help with the healing off the wound and the boots also help prevent wound from occurring for residents at risk. V22 stated the wound to the left heel is improving but if she had the boot on as ordered it would probably improve faster. V22 stated she sees R6 in the clinic every 2 weeks. R6 's Progress Note dated 1/16/2026 titled Weekly Skin Assessment documents R6 refused to move coccyx wound to be assessed I'm tired. Skin overall within normal limits for age and race. Buttocks:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Manor Court of Carbondale		STREET ADDRESS, CITY, STATE, ZIP CODE 2940 W Westridge Place Carbondale, IL 62901	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Unable to Assess. Left Heel dressing clean dry and intact. 1/30/2026 documents R6 refused weekly skin assessment. On 1/30/2026 notes R6 refused to participate in weekly skin checks, would not turn and reposition, only limited exam was able to complete. On 2/10/2026 at 9:10AM when V12 LPN was asked about offloading boots/orders for R1, R2, and R6. V12 stated R2 will not wear the boots because she states they make her feet hot, R1 usually request the boots to be on especially while in bed, and R6 is hit and miss when she will allow the boots to be put in place. V12 was asked if she knows why R2 only has 1 boot in her closet and has an order for boots to bilateral extremities and V12 stated, I don't know. V12 stated she has placed boots on R1 several times, she has offered R2 boots a few times, and R6 sometimes won't allow you to put the boot on. V12 asked this surveyor if the boots were ordered on these residents for while in bed only and V12 explained how the order read which was twice a day 6:00AM-6:00PM and 6:00PM-6:00AM. The facility policy titled Pressure Injury/Pressure Ulcer Prevention and Treatment Protocol revised 10/16/2024 documents objectives and purpose: To ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury or pressure ulcer that might develop. Principles: 3. All high and moderate risk residents will be assessed for the needs of the items and include Elbow/heel protectors/ bridging of heels.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement standard precautions when providing resident care for 1 of 3 residents (R2) reviewed for infection control in a sample of 6. The findings include: R2's Face Sheet documents admission date of 5/12/2022 with diagnoses including Chronic Atrial Fibrillation, Osteoarthritis, Anemia, Essential Hypertension, History of Transient Ischemic Attack (TIA), and Sleep Apnea. R2's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15 indicating R2's cognition is intact. The same MDS documents R2 is dependent on staff for sit to stand, chair/bed-chair, and toilet transfer; R2 is dependent for toileting; and R2 requires substantial/maximal assistance with lying to sitting on side of bed and sitting to lying. Section H, Bladder and Bowel, documents R2 is occasionally incontinent of bladder and bowel. R2's Care Plan documents a focus of Resident Care Information dated 5/12/2022, R2 is incontinent of bladder and bowel and R2 has a personal history of urinary tract infections, with interventions of assist R2 with peri care/incontinence care as needed. On 2/5/2026 at 6:17AM, V9 (Certified Nurse Assistant/CNA) was observed providing peri care to R2. R2 was positioned on left side. V9 removed R2's incontinent brief and began cleaning R2's right buttocks with disposable wipes. After V9 used the disposable wipe to clean R2, V9 threw the wipe in the floor. R2's brief and bed pad were soaked with urine and had a strong urine odor noted. V9 stated he needed to go get a clean pad. V9 left the room, without doffing his gloves or performing hand hygiene, and used his gloved hand to open the door. V9 was then observed getting a clean pad from the clean linen cart and returned to R2's room wearing the same gloves. When V9 returned to R2's room, he then then doffed his gloves and put on a new pair of gloves without performing hand hygiene between glove changes. V9 placed the clean bed pad under the linen and a new disposable brief on R2's bed. When V9 was finished getting linens positioned, V9 stated he would need help and left the room again, without doffing his gloves or performing hand hygiene. V9 returned to the room, wearing gloves, with V4 (CNA) to assist. R2 was then turned to her right side and V9 continued to clean the left buttocks and removed the dirty brief and pad. When V9 removed the soiled bed pad, disposable wipes, and soiled brief from R2's bed, V9 threw them on the floor. When the disposable brief was thrown into the floor, urine was observed splashing onto the floor. V9 then repositioned R2 on her back and began washing R2's peri area. After each wipe, V9 continued to throw the used disposable wipes on the floor. Once peri care was completed and R2 was repositioned, V9 started gathering soiled items off the floor. V9 bundled the used disposable wipes and soiled brief together and folded the soiled bed pad placing it under his arm with the pad touching the right side of his uniform. V9 was observed leaving the room, without doffing his gloves or performing hand hygiene, and went and placed items in the trash and the soiled linen barrel, removing lids with the same gloves still on. V9 then went to the end of the hall, doffed his gloves, and washed his hands. On 2/5/2026 at 6:27AM, V4 CNA was asked if it is policy to place soiled wipes, briefs, and pads on the floor. V4 stated that you must put those items in a bag. V4 was asked if gloves should be worn in the hall and getting items out of the clean linen cart with the same gloves that one used during peri care, V4 stated, no you have to take off the gloves and perform hand hygiene. On 2/5/2026 at 6:30AM, V2 Director of Nursing (DON) approached this surveyor outside of R2's room and asked how the care went. This surveyor informed V2 of the infection control concerns observed with R2's care. V2 was asked if disposing of wipes and soiled brief on the floor during peri care were acceptable practices and V2 stated no. The facility policy titled Infection Control with revision date of 12/17/2019 documents Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions (except sweat),</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard precautions should be applied to the care of all residents regardless of the suspected or confirmed presence of an infectious agent. Standard precautions include but are not limited to 1. Hand Hygiene.3. Proper use of PPE (Personal Protective Equipment), gloves, gowns, mask, etc.5. Care of the environment, textiles, and laundry, 6. Handling of equipment, 7. Disposal of waste. The facility will handle all linen as potentially contaminated using standard precautions.</p>		