STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146171	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor Court of Carbondale	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 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** Based on observation, interview, and record review, the facility failed to ensure a safe resident environment and protection from physical abuse for 1(R4) of 3 residents reviewed for resident-to-resident abuse in the sample of 9. This failure resulted in R4 being bitten on the hand by R2, leaving a bruise. A reasonable person being bitten would feel fearful, threatened and intimidated. R4's admission Record dated 3/4/26 documents an admission date of 4/20/23 and included diagnoses of dementia, traumatic subdural hemorrhage, cognitive communication deficit, and vascular dementia. R4's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 4, indicating R4 has severe cognitive impairment. R4's Care Plan with last revision date of 2/18/26 documents a Problem Category of Mood State (start date 4/24/23) documenting R4 has major depressive disorder and anxiety. R4 has a history of trauma (sexual and other forms of abuse). The Long-Term Care Facility Serious Injury Incident Report documented an incident date of 2/14/26 at 1:54PM and is marked as the final report. The incident category is marked Resident to Resident Altercation and lists R2 and R4 as the residents involved. Both residents are marked as interviewable and capable of communication, but unable to make informed decisions. R3 is listed as a witness to the incident. The detailed incident summary documents On 2/14/2026 at approximately 13:54 (1:54PM), R4 was going through her closet when she was approached by R2 about taking her boyfriend. R4 started yelling that she doesn't want her boyfriend when R2 grabbed R4's hand and bit it. Residents were immediately separated and calmed down. Body assessment was done and R4 has a bruise to the top of her left hand. POA's (Power of Attorneys) and MD's (Medical Doctors) were notified. Both residents will continue to be under close monitoring for any further behaviors and redirected while engaging in separate activity events. An event report for R2 dated 2/14/26 at 1:54 PM documents Notified on call et (and) facility administrator as follows: Res (resident) roommate (R4) sitting in w/c (wheelchair) near closet in their room. This Res (R2) started to raise voice et hit with open fist towards roommate. Bystander nearby called for CNA (Certified Nurse Aide) staff to report fight. This Resident (R2) bit other Res (R4) to L (left) hand causing injury to other Res hand. CNA staff able to separate both residents. This resident is in room. Notified PCP (primary care physician) et POA (Power of Attorney). Awaiting further instructions. Interviews were attempted with R2, R3 and R4 during the survey, but due to all three residents' level of cognition, they were unable to recall the incident or what occurred. R4's Progress Note, authored by V26 (Licensed Practical Nurse/LPN) dated 2/14/26 at 2:03 PM documents, R4 was sitting in her room with R2 when a verbal argument escalated into a physical assault in which R2 bit R4 on the right hand causing bruising that was immediately visible. On 3/2/26 at 2:21 PM, R4 was observed to have a crescent shaped dark purple almost black linear bruise to palmar surface of R4's right hand below the 5th finger. There were no signs or symptoms of infection or slow healing. The crescent moon shaped bruise resembled the outline of a human bite mark. On 3/2/26 at 3:21 PM, V7 (CNA) stated she did not witness R2 bite R4 on the hand on the 14th of February. V7 stated she and another CNA heard a resident (R3) yelling that someone was fighting. V7 stated she does not remember the exact time, but it was after lunch between approximately 12:00 PM (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	and 1:00 PM. V7 stated, We ran down to their (R2 and R4's) room and R4 was still in her closet and R2 was on the other side of the room. R4 was holding her hand and said, ?She bit me,' meaning R2. V7 stated R4 told her initially the bite did not hurt. V7 stated she wheeled R4 up to the nurse's station for evaluation and treatment by the nurse. V7 stated by the time she had entered the room, R2 and R4 had separated. V7 stated R4 did have a bite mark with bruising on her right hand. V7 stated the injury was closed, the skin was not broken. V7 stated R2 and R4 don't frequently fight but usually get along. V7 stated she is not sure exactly what caused the altercation to begin with. V7 stated she did remember when walking into the room R4 stating, I don't want her man repeatedly. On 3/2/26 at 3:31 PM, V8 (CNA) stated she was doing rounds on 2/14/24 a little after lunch time when she heard screaming from the other side of the unit. V8 stated, So I sprinted down there, and they (R2 and R4) were already separated by the time I got there. When I walked in the room R2 was wheeling herself back to her bed and R4 was facing us (staff) wheeling herself toward the door. R4 was holding out her hand and I saw a blood blister on the palm side, and when I asked what happened she (R4) stated, ?She (R2) bit me.' V8 stated there also appeared to be lipstick around the bite area. V8 stated R2 refused to speak to them or the nurse and tell them what happened. V8 stated the wound in question to R4's right hand appeared to be in a crescent moon shape that looked like a human bite. On 3/2/26 at 3:42 PM, V26 (LPN) stated she remembers the incident between R2 and R4 on 2/14/24. V26 stated she remembered hearing yelling and one of the other residents stated they were fighting in there, meaning R2 and R4's room. V26 stated one of the CNAs (she said she didn't remember who) said R2 bit R4 on the hand. V26 stated the CNA's got the two residents separated and brought R4 to her for evaluation and treatment. V26 stated R4 kept telling her that her right hand was hurting. V26 stated when she looked at R4's right hand it had a bruise on the palmar side in the shape of a human bite or crescent moon. V26 stated the skin wasn't broken. V26 stated she immediately notified R4's primary physician who said to clean the area and put a dry bandage over it. V26 stated she then notified V1 (Administrator) and both residents' power of attorneys and the on-call nurse manager. On 3/5/26 at 9:10 AM, V23 (Memory Care Director) stated she was not here the day of the alleged assault of R4 by R2. V23 stated she was notified shortly after by telephone that the alleged assault had occurred. V23 stated she gave instructions for staff to monitor R2 the rest of the day until bedtime. V23 stated R2 was already on special frequent checks due to her recent uptick in behaviors and agitation. V23 also stated R2 is care planned for behaviors as well and has a sticker on her door to notify staff she is to be checked on frequently and to track her behaviors in the electronic health record (EHR). V23 stated the day she returned to work she also started tracking R4's mood for a few days to make sure she wasn't acting depressed, scared or anxious in any way after the alleged assault, and she stated R4 did not. V23 stated the reason a room change wasn't instituted for either R2 or R4 was because both residents have dementia, and a room change risked increasing confusion and agitation for one or both. V23 also stated R4 was pointedly asked and rechecked frequently to see if she was afraid, and she denied that she was. V23 stated with the information above, the facility administration staff thought it was best to leave them as roommates. V23 stated R2 has not had any episodes like this before or after this event directed towards R4 or any other residents. V23 stated she believes overall R4 is safe. On 3/5/26 at 1:28 PM, V1 (Administrator) stated she was notified of the alleged assault of R4 by R2 right after it happened because she remembers it being early afternoon. V1 stated she was informed that R4 didn't show any signs of fear even immediately after the incident. V1 stated she verified R2 and R4 were immediately separated and put into separate activities. V1 stated R2 and R4 were monitored closely that evening, and due to R4 not showing any signs of fear and R2 not showing any more signs of aggression, the facility administration chose not to make a room change because sometimes that can increase confusion and agitation. V1 stated she believed there was nothing the facility could have done to prevent the incident. V1 stated R2 had never shown aggression in the past to her peers, so this was unexpected. V1 stated she also believed facility staff handled the incident appropriately. The facility's abuse policy dated revised 11/28/19 documents, The facility actively (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	prohibits resident abuse. Same policy documents, Special attention will be given to identifying behavior that increases the resident's potential for abusing self or others or being the victim of abuse.