STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049239	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLINVILLE REHAB & HCC	**751 NORTH OAK STREET , CARLINVILLE, Illinois, 62626**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint # 25411562/2679361 Complaint # 25411783/2684568 Complaint # 25411920/2686160 Facility Reported Incident of 12-3-25/ 2697826	S0000		01/06/2026
S9999	Final Observations Statement of Licensure Violations ONE OF TWO 300.610a) 300.3240d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.3240 Abuse and Neglect d) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) These requirements were not met as evidenced by:	S9999		01/06/2026

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

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S9999	Continued from page 1 Based on interview and record review the facility failed to follow their own policy of providing a thorough investigation of abuse by not properly identifying the alleged staff involved for 1 of 3 (R22) residents investigated for abuse in a sample of 23. This failure led to the resident fearing of retaliation by one of the alleged individuals. Findings include: R22's EMR (Electronic Medical Record) undated documents that the resident was admitted to the facility on 5/21/24. R22's EMR dated 12/18/23 documents a diagnosis of Major Depressive Disorder, recurrent, moderate. R22's EMR dated 5/18/23 documents a diagnosis of Morbid (severe) Obesity due to excess calories. R22's EMR dated 12/20/23 documents a diagnosis of Chronic Obstructive Pulmonary Disease, unspecified. R22's MDS (Minimum Data Set) dated 11/7/25 documents a BIMS (Brief Interview for Mental Status) score of 15 out of 15. The MDS documents that the resident has little interest or pleasure in doing things 7-11 days (half or more of the days); feeling down, depressed, or hopeless 12-14 days (nearly every day); trouble falling or staying asleep, or sleeping too much 12-14 days (nearly every day); feeling tired or having little energy 12-14 days (nearly every day); poor appetite or overeating 12-14 days (nearly every day); feeling bad about yourself – or that you are a failure or have let yourself or your family down 12-14 days (nearly every day); trouble concentrating on things, such as reading the newspaper or watching television 12-14 days (nearly every day); and moving or speaking so slowly that other people have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual 12-14 days (nearly every day). The MDS documents that the resident requires partial/moderate assistance for roll left and right, sit to lying, and lying to sitting on side of bed. The MDS documents that the resident requires substantial/maximal assistance for sit to stand, chair/bed to chair transfer, and toilet transfer. R22 does not have a care plan for abuse. Facility's Abuse Investigation dated 11/23/25 documents "Final Report: On 11/23/25 resident (R22) (DOB:10/18/1973) reported two CNAs (Certified Nursing	S9999		

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S9999	Continued from page 2 Assistant) were in his room and one of the two stated to him to, “shut his fat f***ing mouth”. Through description it was initially decided that (R22) was referring to CNA (V25) and she was immediately suspended pending outcome of an investigation. An assessment was completed, and no injuries or concerns were noted. (R22) is his own person. The Ombudsman and (local police department) were notified (CAD [Computer-Aided Dispatch]: 25-38612). An investigation was started, and an initial report was submitted. During the investigative process it was discovered (V25) was incorrectly identified as one of the CNAs in question. The two CNAs identified through further description, subsequent interviews and review of schedules and report times were (V24) and agency CNA (V26). (V24) was immediately suspended and (V26) has been put on the “Do Not Rehire” list and has no further scheduled shifts. Witness statements were obtained from staff and residents. All residents reported to feel safe in the facility. Resident (R23) reported (V24) to be “just rude” when interviewed. However, she did state she had not been verbally abused. Resident (R5) reported CNAs (V25) and (V26) to be rude. All interviewed residents stated they had not been verbally abused by any CNA including the three in question. While interviewing resident (R22), he explained he had requested assistance from his CNAs at approximately 3:30am and they became irritated with him. He reported the taller of his CNAs (V24) on the morning of November 21st told him, “They don’t have time, shut your fat f***ing white mouth.” He explained he found it more bothersome as they both continued to walk by his room laughing and taunting him. (V26) did not respond to attempts to be interviewed. (V24) was interviewed and denied the allegation. She explained she had never had an issue with him prior to that night and he had kicked her and (V26) out of his room, cussing at them and calling names. Both LPNs (Licensed Practical Nurse) working the overnight shift stated they were unaware of either CNA being discourteous to (R22). CNA (V28) who was working the same day and shift reported (V24) told her resident (R22) had been racist and cussed at her and CNA (V26). CNA (V28) stated her co-worker, CNA (V24), had disclosed she had shut resident (R22’s) door and was going to stay away from him for the remainder of her shift. Resident (R22) has a diagnosis of chronic obstructive pulmonary disease, type 2 diabetes, shortness of breath, cellulitis, paroxysmal atrial fibrillation, morbid obesity, major depressive disorder, unspecified atrial fibrillation, panniculitis, chronic kidney disease – stage 3, need for assistance with personal care, muscle weakness, unsteadiness on feet, left knee pain. After thorough investigation, we did not find evidence to substantiate	S9999		

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S9999	Continued from page 3 (R22)'s allegation. However, we did find that CNA (V24) in need of customer service re-education along with CNA (V25). Agency CNA (V26) will continue to be on the facility DO NOT HIRE list. She will not return to the facility as an agency employee any further. The Social Service Director completed a trauma assessment with Resident (R22). IDT (Interdisciplinary Team) reviewed the incident and care plan. It was determined that the care plan is appropriate. SSD will complete one-on-one follow-up discussions with (R22) for the next three weeks to ensure his psychosocial needs are met." Re-education Form dated 11/26/25 documents that (V24) was educated on customer service, treating residents with respect. Discussed the importance of treating customers/residents with respect and kindness. Reminder this is their home. Professional attitude at all times and following resident rights." Police Report dated 11/23/25 at 6:38 PM documents "Calling to adv. (advise) A resident, (R22), reported that CNA (V25) came into his room and told him to "shut his fat f***ing mouth," (V25) was suspended and removed. Relayed CAD number." On 12/16/25 at 9:22 AM, R22 stated that back in November, he had turned on his call light to go to the bathroom. He stated that after waiting 1 and half hours, 2 CNAs walked into his room. He stated that he told the CNAs what took you so long, I have to go to the bathroom. He stated that the tall African American CNA told him to "shut your fat white f***king mouth and sit in your chair". He stated that the short red head CNA with her laughed. He stated that the two CNAs left his room and slam his door. He stated that he did not say anything to the CNAs or call them any names at the time of the incident. He stated that they did not take him to the bathroom. He stated that the next day the short redheaded CNA came back and apologized to him for laughing. He stated that 2 and 1/2 hours later another staff member finally took him to the bathroom. He stated that the tall CNA was suspended and when she came back is not supposed to work on his hall. He stated that she still works on his hall but does not take care of him. He stated that at least 5 times since the incident this CNA has walk past his room, looked at him and laughed. On 12/16/25 at 10:05 AM, V1, Administrator, when asked about the (R22) incident, stated that she might have the CNAs mixed up in her investigation. She stated that the only CNA that still works here is (V24). She stated that she needs to call her boss to find out what she should do. V1 had brought this writer the abuse investigation folder but took it back when she realized	S9999		

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S9999	Continued from page 4 it might be incorrect. On 12/16/25 at 10:45 AM, V1, Administrator stated that she panicked about the investigation because she thought she fired the wrong CNA. She stated that her and the DON (Director of Nursing) went back to talked to (R22) and he said that he could not remember everything. She stated that she is unsure who said what and that (R22) has a history of exaggerating. She stated that he is care planned for it. She stated that (V24) is not allowed to care for (R22). She stated that (R22) told her that he told the CNAs to get out of his room at the time of incident. On 12/16/25 at 11:20 AM, R22 stated that at the time of the incident he was really p***ed off. He stated that after the incident happened that (V5) had to come and calm him down. He stated that he is still upset about what she (V24) said. He stated that he tries to ignore (V24) and tries not to look at her when she is working his hall. On 12/17/25 at 8:34 AM, R22 stated that he would worry after the incident that (V24) would retaliate on him. He stated that (V2), DON and (V5) came down and talked with him yesterday. He stated that they told him that he did not have to worry about (V24) stepping one foot into his room. He stated that up until yesterday he was worried about that (V24) would come into his room saying something or smack him. On 12/17/25 at 10:57 AM, V26, agency CNA stated that she had personal issues going on and did not work her agency job or her other job from 18th of November until the Monday after Thanksgiving. She stated that if she would have heard someone say that to a resident that she would report them herself. On 12/17/25 at 12:03 PM, V25, former CNA stated that she did not hear anyone say derogatory remarks to (R22). She then stated that she did not work that day (11/20/25). On 12/17/25 at 12:09 PM, V1, Administrator stated that she figured out what happened. She stated that the incident happened on 11/20/25 and not 11/23/25. She stated that it was reported to the facility on the 23rd so they assumed that is when it happened. Facility's "Abuse, Prevention and Prohibition Policy" dated November 2025 documents "Investigation: Resident abuse must be reported immediately to the Administrator. The facility Administrator will ensure a thorough investigation of alleged violations of	S9999		

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S9999	Continued from page 5 individuals rights and documents appropriate action." (NO VIOLATION) TWO OF TWO 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)1)2) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and	S9999		

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S9999	Continued from page 6 services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to administer an ordered intravenous, IV, antibiotic, timely transport, and contact prescribing Physician for 1(R2) of 3 residents in the sample of 23. This failure resulted in R2's course of treatment being interrupted, R2 needing to have six additional days of IV antibiotics, and the potential of septic infection. Findings include: R2's undated face sheet documents an admission date of 11/28/2025 and a discharge date of 12/4/2025. Diagnosis include Fournier Gangrene, Chronic Kidney Disease, Bacteriuria, Urinary Tract Infection, Acute Kidney Failure, Malignant Neoplasm of Rectum, Colostomy Status. R2's Minimum Data Set, MDS dated R2's MDS dated 12/5/2025 documents R2 has no cognitive deficits. R2 is dependent for rolling, sitting and transfers. R2's baseline care plan dated 12/4/2025 documents The resident has Catheter: Neurogenic Bladder. Interventions include Catheter Care, Position catheter bag and tubing below the level of the bladder and away from entrance room	S9999		

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S9999	Continued from page 7 door. R2's order sheet dated 11/28/2025 Ceftazidime-Avibactam Intravenous Solution Reconstituted 2.5 (2-0.5) GM (Ceftazidime-Avibactam Sodium) Use 0.94 gram intravenously two times a day for antibiotic until 12/08/2025 11:59PM. R2's November medication administration sheets, MARS, dated 11/1/2025-11/30/2025 documents Ceftazidime-Avibactam Intravenous Solution Reconstituted 2.5 (2-0.5) GM (Ceftazidime-Avibactam Sodium)Use 0.94 gram intravenously two times a day for ABT until 12/08/2025 11:59PM. R2's 11/28/2025 PM, 11/29/2025 AM and PM dose, 11/30/2025 AM and PM doses all marked as "Hold". R2's December medication administration sheets, MARS, dated 12/1/2025-12/31/2025 documents Ceftazidime-Avibactam Intravenous Solution Reconstituted 2.5 (2-0.5) GM (Ceftazidime-Avibactam Sodium) Use 0.94 gram intravenously two times a day for ABT until 12/08/2025 11:59PM. R2's 12/1/2025 AM and PM doses and 12/1/2025 AM and PM doses marked as "Hold". R2's progress notes dated 11/28/2025 at 7:00AM document The nurse reported that R2 was newly admitted to the facility with intravenous, IV, antibiotics for Clostridioides difficile, C diff, and Extended Spectrum Beta-Lactamase, ESBL, in the urine. The pharmacy informed that the ordered antibiotic is not available and cannot be supported. The nurse was advised to contact the hospital or prescribing provider to request an alternative medication. The patient remains stable per the nurse. Rounding provider to follow up. R2's progress notes dated 11/28/2025 at 5:15PM documents Call received from pharmacist at to notify that he cannot	S9999		

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S9999	Continued from page 8 supply IV antibiotic until Monday 12/1/2025 due to having to order from a different pharmacy. R2's progress notes dated 11/28/2025 at 5:32PM documents Received call from pharmacist. Pharmacist states that he is unable to obtain IV antibiotic for supply, he is also unable to suggest appropriate interchange due to not having culture and sensitivity for reference. V23, Facility Nurse Practitioner, NP, notified of above, with suggestion to attempt to contact ordering hospitalist for new antibiotic. current order antibiotic to be placed on hold pending new order R2's progress notes dated 11/29/2025 at 11:32PM document Antibiotic/ESBL urine/CDIFF (Vancomycin) IV antibiotic remains on Hold until Monday. No adverse side effects, ASE, noted from medication, Afebrile. R2 voicing no concerns/complaint/discomforts. Able to make needs and or wants known. IV site free of signs of infection with dressing clean, dry, intact, CDI. R2's progress notes dated 12/1/2025 at 11:57AM document Health Status Note Note Text: call placed to V20, Infectious Disease Physician, at this time to notify of unavailable antibiotic order, message provided to nurse in with patient. awaiting response. R2's progress notes dated 12/3/2025 at 5:04PM documents Received call from nurse V20's office with orders to send R2 back to hospital for continuing treatment of IV antibiotics if unable to obtain from any pharmacy for treatment outside of hospital. Per V20 statement is he will not change the IV medication as it is the only medication that can be used.	S9999		

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S9999	Continued from page 9 R2's progress notes dated 12/3/2025 at 6:26PM documents Emergency Medical Services, EMS, in facility, refusing to take resident to Emergency Department, ED. R2's progress notes dated 12/3/2025 at 7:38PM out of town EMS refused at 6:23PM. Out of town EMS refused at 6:25PM. Out of town EMS at 6:36PM refused. Out of town EMS at 7:01PM refused. Out of town EMS at 7:37PM refused. Out of town EMS at 7:42PM refused. Out of town EMS at 7:45PM refused. Out of town EMS at 8:08PM refused. Out of town EMS at 8:18PM refused. On 12/9/2025 at 12:46PM V4, Minimum Data Set, MDS Coordinator, stated R2 was discharged on an IV that is usually only given in hospitals. We got a hold of the Infectious Disease Doctor, IDD, and the IDD wanted R2 to go back to the hospital for the IV med to be given there. Then we had an issue with getting him back to the hospital. We could not get an ambulance to come get him. He was almost 500# and was too big for us to take him in our van. We have our own transportation but R2 was too wide to fit. On 12/11/2025 at 11;30AM V4 stated I did not realize the order to hold the IV antibiotic did not come from V20. The order came from V23. On 12/9/2025 at 12:49PM V2, Director of Nursing, DON, stated R2 came to the facility on 11/28/2025. The pharmacy could not get the IV antibiotic until 12/1/2025. He was still on his oral antibiotics. We called and got a hold of V20 he said to hold the IV antibiotic until 12/1/2025. The pharmacy then said they could not get the IV antibiotic at all. We tried	S9999		

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S9999	Continued from page 10 several times to get a hold of V20. V20's office finally called on 12/3/2025 and said R2 could only get that IV antibiotic in the hospital. I was here until 10:00PM on 12/3/2025 trying to get different ambulance companies to agree to transport R2. We called bariatric companies and could not get anyone to come. Finally, a company agreed to come get him on the morning of 12/4/2025. On 12/11/2025 at 11;30AM V2 stated I was under the impression the order to hold the antibiotic was from V20. The order came from V23. On 12/11/2025 at 12:45PM V3, Assistant Director of Nursing, ADON, stated R2 got here on 11/28/2025. Pharmacy called and said they could not get the IV antibiotic that was ordered. We tried to call V20, and they were unavailable, and it was the weekend. We called V23 that is over us and V23 is who gave us the order to Hold the IV antibiotic until Monday 12/1/2025 when we could get in touch with V20. On 12/11/2025 at 2:00PM V20 stated "The facility should not have accepted (R2). By the facility accepting (R2) and then not being able to provide prescribed antibiotic caused an interruption in treatment. This was a "near miss" for (R2) and it is unacceptable. There was a miscommunication between the hospital and the facility. The antibiotic prescribed is very expensive and no facility can afford it. (R2) was readmitted with an abscess of the pelvis and needed another 6 days	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 11 of antibiotic therapy due to the interruption of therapy. (R2) needed assessment and to resume antibiotic therapy. Our office was not notified that (R2) was not getting the antibiotic until 12/2/2025." On 12/12/2025 at 11:00AM V20, ID, stated When I say (R2) was a "near miss" I mean (R2) had the potential for septic infection and recurrence of infection. (R2) was readmitted with an abscess of the pelvis and needed another 6 days of antibiotic therapy due to the interruption of therapy." On 12/12/2025 at 11:15AM V22, Pharmacist, stated "I dealt with this situation involving (R2). The reason the antibiotic was unavailable was due to the logistics of the antibiotic. It was unavailable from our primary and secondary supplies. The reason is the dose of the drug. It is a mandatory compound drug. It is a very new drug. It is very unstable. It is for immediate use only. There is no extended stability. The drug is so new and so unstable it would have to be sent out every 12 hours. (R2) should've never left the hospital. Had we been contacted prior to (R2) being discharged I would've been able to tell them that this antibiotic was unavailable. We don't typically get advanced notice. We don't typically get forms prior to admission." On 12/16/2025 at 11:15AM V1, Administrator, and V5, Social Services Director, SSD, stated "All our referrals go through our corporate office. A clinical liaison through our corporate office is who does the screening and they let us know who and when they will be	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0049239	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

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S9999	Continued from page 12 coming. We may get 2-day notice or we may get 1 hour. V5, SSD, stated I give V2, DON, the packet when I get it for her to look at the orders." On 12/16/2025 at 12:35PM V2, DON, stated “On 11/26/2025 in the afternoon was my first day as DON. On 11/26/2025 I received the discharge packet for (R2). In the packet were his preliminary orders. I am not sure if those orders were sent to pharmacy or not. Then the next day was Thanksgiving. The orders could've gone to Pharmacy on 11/28/2025.” Facility Medication Administration policy dated 11/2025 states “Medications shall be administered according to established schedules. Administration times can be changed to meet each facility's unique resident population and to maintain compliance with state and federal laws. A physician's order for specific times supersedes any routine schedule. Residents may request alternate medication schedules. Such times must be documented on the resident's medication administration record and care plan.” (B)	S9999		