STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S 000	Initial Comments First Probationary Licensure Survey for Change of Ownership	S 000		
S9999	Final Observations Statement of Licensure Violations I. of V. 300.610 a) 300.1210 d)1)2)3) 300.1810 h) 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 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. 3) Objective observations of changes in a resident's condition, including mental and	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 1 emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1810 Resident Record Requirements h) Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow physician orders for acquiring resident vital signs and failed to administer 2 as needed medications for 1 of 3 residents (R14) reviewed for medication administration in the sample of 71. This failure resulted in R14 experiencing excessive pain and distress due to unrelieved coughing for multiple days. Findings include: R14's Electronic Health Record documents R14's diagnoses include Systolic Heart Failure, Anxiety Disorder, Long Term use of Anticoagulants, Major Depressive Disorder, Essential Hypertension, Allergic Rhinitis, Muscle Spasms, and Hyperlipidemia. R14's Minimum Data Set (MDS) Section C: Cognitive Patterns, dated 1/1/22 documents a	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 2 Brief Interview of Mental Status (BIMS) score of 13, which indicates R14 is cognitively intact. R14's Physician Order dated 1/5/22 documents an order for Tylenol 650 mg Q4hr (Every 4 Hours) PRN (As Needed), Mucinex 600 mg BID (Twice Daily) x 10 days, Robitussin 5 ml (milliliters) every 4 hours PRN, albuterol 90 MCG (Micrograms) 2 puffs every 4 hours PRN x 10 days, Vitamin C 500 mg BID x 10 days, VS (vital signs) Q4H. O2 above 90% - IF<90 and O2 not available sent to ED (Emergency Department). R14's Physician's Order Sheet, dated January 2022 document R14 has an allergy to guaifenesin, and no Mucinex 600 (guaifenesin) was given. On 1/11/22 at 11:10 AM, R14 appeared distressed; R14 had R14's arms wrapped around self, with a slight rocking back and forth. R14's eyes were tearful, and R14's face was red and grimacing. R14 had a frequent deep, hoarse sounding cough. R14's cough could be heard down the hallway. On 1/11/22 at 11:10 AM, R14 stated, R14 has a bad cough and that R14 has had it for approximately a week now. R14 stated, the cough makes R14's chest and back hurt "really bad." R14 said R14 just wants to lay there and cry "it hurts so bad." "This cough is just awful." R14 said R14 does not know what is wrong with R14, they have not told R14. R14 stated R14 does not see a doctor very often. R14 then stated, R14 had a fever for about a day or so R14 believes. R14 was told R14 was going to get a chest X-ray, but R14 never had one. On 1/11/22 at 11:05 AM, R13's (R14's	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

Roommate) who was alert to person, place and time stated, R13 cannot get any sleep because "everything is too loud at night, between peoples' TVs and everyone coughing." R13 said R13 knows R13's roommate (R14) cannot help that (R14) is coughing all the time, and all night, because (R14) is sick. R13 stated, "but it keeps (R13) awake."

On 1/11/22 at 11:15 AM, V24 (Certified Nurse Aide/CNA) stated, R14 has been coughing, R14 sounds pretty bad at times.

On 1/11/22 at 1:45 PM, V36 (CNA) stated, she has heard R14 coughing, sometimes it sounds harsh.

On 1/11/22 at 2:30 PM, R14 could be heard from the hallway coughing.

On 1/12/22 at 10:10 AM, R14 could be heard coughing from the hallway.

On 1/12/22 at 10:10 AM, R14 stated, this cough is still awful, it makes my back and lungs hurt awfully.

On 1/31/22 at 2:05 PM, R14 stated, they (the nurses) did not ask R14 everyday if R14 would like anything for the cough. R14 did not always ask for anything because, R14 just felt too bad and was too miserable to care. R14 also gets tired of feeling like R14 has to fight with them to get any pain medication. If it hurts and they know it, why can't R14 just have R14's pain medication? R14 thought V43 (Attending Physician) wrote R14 a script for pain medication.

R14's electronic Medication Administration Record (eMAR) dated January 2022, shows no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 4 documentation that Tussin (Robitussin) or Acetaminophen were administered on 1/11/22 or 01/12/22. R14's Electronic Medical Record documents from 1/05/22 through 1/15/22, R14's vital signs were obtained on one occasion (1/10/22 at 1:24 PM) and not every 4 hours as ordered on 1/5/22. On 1/4/22 at 3:50 AM, a progress note by V38 (Licensed Practical Nurse/LPN) for R14 documents: Resident with cold like symptoms; scratchy throat, redness of b/l (Bilateral) eyes, low grade temp, will continue to monitor. No other progress notes for R14 from 1/4/22 through 1/12/22 addresses these symptoms. The next progress note to address these symptoms again for R14 was on 1/13/22 at 7:18 PM, which documents, R14 remains alert and oriented x 3 with occasional forgetfulness noted, respirations even and non-labored, continues to have a non-productive cough that is harsh at times with relief from PRN Tussin given, lung sounds diminished in lower bases, no other signs or symptoms of distress noted. On 1/12/22 at 2:55 PM, V17 (Registered Nurse/RN) stated, she does not see where R14 received any Tussin or Acetaminophen on the 11th or yet today (1/12/22) for R14's cough. R14 does have a bad cough, and R14 should have received some. V17 (RN) stated, she is unaware of why R14 did not receive any. V17 stated, she does not see any other progress notes, besides the one on 1/4/22, that describes any monitoring of R14's respiratory symptoms. On 1/12/22 at 2:55 PM, V18 (Human Resources Generalist) stated, (R14) does have a bad cough, and said she has heard (R14) coughing.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 5 On 1/18/22 at 1:33 PM, V17 (RN) stated the 1/5/22 Physician Order for the vital signs to be taken every four hours should have been put into the eMAR, but V17 did not see where that occurred, therefore the ordered vital signs were not obtained. On 2/1/22 at 11:47 AM, V42 (Advanced Practiced Nurse/APN) stated, she did not see R14 on 1/5/22, there was a standing order put in for the "Covid-19 protocol" which was for any resident showing signs and symptoms of Covid-19, which was the Tylenol 650 mg (Every 4 Hours) PRN (As Needed), Mucinex 600 mg BID (Twice Daily) x 10 days, Robitussin 5 ml (milliliters) every 4 hours PRN, albuterol 90 MCG (Micrograms) 2 puffs every 4 hours PRN x 10 days, Vitamin C 500 mg BID x 10 days and VS (vital signs) every four hours. During the time the facility had several Covid-19 positive residents in a short time frame, she was in close contact with V19 (LPN) on who has tested positive and who had symptoms. R14 still had a cough and some breathing issues around 1/19/22, so an X-ray was ordered. V43 (Attending Physician) saw R14 on the 1/21/22. Facility Policy titled Subject: "Medication Therapy" (Therapy) dated 04/24/2014 with a revised date of 04/28/2021 states: Time Frame: .....Administration of "PRN" or "As Needed" Medication 1. PRN medication are allowed as follows: ... ... b. If the resident is showing signs of need, the LN (Licensed Nurse) may confer with resident on availability and need. Note body language or actions. ... ...5. Documentation will be completed after administering medication in EMAR including, reason for Administration, Dosage, Response or any medication effects.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 6 "B" Statement of Licensure Violations II. of V. 300.610 a) 300.696 a) 300.696 b) 300.696 c)2)6) 300.1020 a) 300.1020 b) 300.2030 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 300.696 Infection Control a) Each facility shall establish and follow policies and procedures for investigating, controlling, and preventing infections in the facility. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. Each facility shall monitor activities to ensure that these policies and procedures are followed. b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 7 c) Each facility shall adhere to the following guidelines and toolkits of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, and Agency for Healthcare Research and Quality 2) Guideline for Hand Hygiene in Health-Care Settings 6) Guideline for Isolation Precautions: Transmission of Infectious Agents in Healthcare Settings Section 300.1020 Communicable Disease Policies a) The facility shall comply with the Control of Communicable Diseases Code (77 Ill. Adm. Code 690). b) A resident who is suspected of or diagnosed as having any communicable, contagious or infectious disease, as defined in the Control of Communicable Diseases Code, shall be placed in isolation, if required, in accordance with the Control of Communicable Diseases Code. If the facility believes that it cannot provide the necessary infection control measures, it must initiate an involuntary transfer and discharge pursuant to Article III, Part 4 of the Act and Section 300.620 of this Part. In determining whether a transfer or discharge is necessary, the burden of proof rests on the facility. Section 300.2030 Hygiene of Dietary Staff Food service personnel shall be in good health, shall practice hygienic food handling techniques, and good personal grooming. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 8 review, the facility failed to implement infection control measures to prevent and/or contain Covid-19 as evidenced by 1. Failure to provide adequate resident supervision to ensure Covid-19 positive residents remain within the designated Covid-19 isolation areas and away from Covid negative residents. 2. Failure to ensure residents testing positive and/or developed symptoms of SARS CoV-2 (Covid-19) were isolated per current standards of practice to prevent the spread of Covid-19. 3. Failure to ensure proper use of PPE (Personal Protective Equipment), hand hygiene, and prevention of cross contamination according to current standards of practice. 4. Failure to ensure disinfectants used to treat non-porous surfaces for Covid-19 were utilized per manufacturer guidelines. These systemic failures have resulted in 54 residents (R1, R3, R4, R5, R6, R7, R8, R9, R11, R15, R17, R18, R19, R20, R22, R24, R25, R26, R27, R29, R31, R32, R35, R36, R38, R39, R40, R41, R42, R43, R44, R45, R48, R49, R50, R51, R52, R53, R54, R55, R56, R57, R58, R59, R60, R61, R62, R63, R64, R65, R66, R67, R68, and R69) testing positive for Covid-19, with death being the result for 3 of these residents (R11, R36, and R66) who were confirmed positive for Covid-19. These failures have the potential to affect all 74 residents residing in the facility. Findings Include: On 1/11/22 at 11:00 AM, V2 (Director of Nursing/DON) stated, the document titled "Census Detail Report" dated 1/11/2022 documents the current census as 74, and the information on it is correct including room numbers. On 1/11/22 at 10:20 AM, V1 (Administrator) stated, there are currently 40 positive residents in	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 9 the facility. Staff are supposed to wear N95 and eye protection when in the facility. They currently do not have a Covid-19 unit, the positive residents are located on all the halls with Transmission Based Precaution signage outside their room. Staff should be donning PPE and performing hand hygiene after exiting a room that houses a Covid-19 positive resident. On 1/11/22 at 11:30 AM, V1 (Administrator) stated, V2 (DON) has a line list with the resident's names and date of positive test for Covid-19. On 1/18/22 at 9:12 AM, V1 (Administrator) stated the "Line List" is the updated list of the residents that have tested positive for Covid-19 with their test dates. On 1/18/22 the untitled, undated document, referred to as the "line list" documents the resident's name and date of positive test for Covid-19. The Line list documents on 1/2/22 three residents (R6, R7, and R11) tested positive for Covid-19. On 1/3/22 one resident (R8) tested positive for Covid-19. On 1/5/22 two residents (R5 and R52) tested positive for Covid-19. On 1/7/22 twenty-six residents (R1, R4, R9, R24, R25, R31, R35, R36, R38, R39, R41, R43, R48, R49, R50, R53, R54, R55, R56, R57, R58, R59, R60, R61, R62, and R63 tested positive for Covid-19. On 1/8/22 one resident (R64) tested positive for Covid-19. On 1/9/22 one resident (R18) tested positive for Covid-19. On 1/10/22 eight residents (R15, R26, R32, R42, R44, R45, R65, and R66) tested positive for Covid-19. On 1/12/22 eight residents (R3, R17, R19, R20, R22, R40, R51 and R67) tested positive for Covid-19. On 1/14/22 two residents (R27 and R68) tested positive for Covid-19. On 1/17/22 one resident (R69) tested positive for Covid-19. On 1/20/22	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 10 one resident (R29) tested positive for Covid-19. Of these residents, three residents (R8, R17 and R18) were hospitalized and three residents (R11, R36 and R66) expired. The State Death Certificate for R11 documents Date of Death as 1/5/22 and Cause of Death: a. Covid-19, b. Heart Failure, c. Hypertensive Heart Disease. Approximate interval between onset and death for a. Covid -19 is documented as: "Days," (for b. and c. it is documented as "Years"). The State Death Certificate for R36 documents Date of Death as 1/13/22 and Cause of Death: a. Acute Respiratory Failure, b. SARS Covid-19 Pneumonia. The approximate interval between onset and death for both a. and b. is documented as "1 week." The State Death Certificate for R66 documents Date of Death as 1/18/22 and Cause of Death: a. Novel Corona Covid-19 Virus Infection Virus Infection, b. Dementia, c. Hypertensive Heart Disease. The approximate interval between onset and death for a. is documented as "Days" and both b. and c. is documented as "Years." R8's Electronic Medical Record's progress note documents R8 was sent to the hospital on 1/3/22 after complaints of not feeling well and having a fever of 102 degrees Fahrenheit that was not reduced with Tylenol. R8 was diagnosed at hospital with Covid-19. R17's Electronic Medical Record's progress note documents R17 was sent to the hospital on 1/12/22 with complaints of congestion, severe cough and minimal secretions. R17 tested positive for Covid-19 at the hospital and returned to the facility with a diagnosis of Pneumonia due	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 11 to Covid-19. R18's Electronic Medical Record Census detail documents R18 was sent to the hospital on 1/9/22. R18's progress note documents R18 had complaints of shortness of breath and cough. R18's hospital records document R18 tested positive for Covid-19 at the hospital and returned to the facility, after a six-day hospital stay, with a diagnosis of Acute Respiratory failure with hypoxia due to Covid-19 Pneumonia and Non-STEMI with demand Ischemia secondary to Covid-19 and Acute Pulmonary Embolism. 1. On 1/4/22 at 8:35 AM, R1 was alert and oriented to person, place, time, and purpose. R1 stated R1 has not been vaccinated for Covid as R1 has chronic health conditions which render R1 a non-candidate. R1's Medical Record listed diagnoses of Muscular Dystrophy, Parkinson's Disease, Hypothyroidism, and Bipolar Disorder. On 1/4/22 at 11:40 AM, R6 was observed ambulating alone in the second-floor hall in front of R1's room. R6 was not wearing a mask. R6 did not verbally respond to the surveyor. V10 (Certified Nursing Assistant) was observed coming down the hall and intercepting R6, taking R6's arm and slowly guiding R6 back to R6's room as R6 was somewhat resistive. V10 was not wearing a gown, stating she did not have time to don one when she saw R6 in the hall. V10 stated R6 is on isolation due to being Covid positive. V10 stated R6 is confused, and staff have difficulty keeping R6 in R6's room. An isolation supply bag was observed on R6's door, and isolation linen and trash barrels were observed	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 12 within the room. R6's Medical Record documented a 1/02/22 diagnosis of "Covid-19". R6's Nursing Progress Notes documented the following: 1/2/22: "Left message for (family member) regarding (R6) testing positive for Covid 19." 1/4/22:" Evening Assessment: Resident alert and oriented to self with much confusion. Refused to stay in room - attempted some wandering into other residents' room. Isolation precautions related to positive Covid (status) attempted." 1/5/22: "Occasional non-productive cough, continues on isolation precautions, frequent reminders to stay in room required .. as resident has attempted to exit room several times." 1/6/22: "Evening Assessment: Isolation precautions continue related to Covid. Resident is alert with confusion. (R6) Attempted to wander (the) hall per usual." R6's Minimum Data Set dated 12/10/21 documented a Brief Interview for Mental Status Score of 99, indicating R6 is so severely cognitively impaired the test questions could not be asked. On 1/7/22 at V2 (Director of Nurses) stated when R6 was placed on isolation on 1/2/22, V2 anticipated having difficulty keeping R6 in R6's room. V2 stated consideration was given for either providing R6 with one-to-one staff supervision or placing R6 on the South Hall quarantine unit, where there are positive and presumed positive residents. 2A.) On 1/11/22 at 12:22 PM, R50 and R51 were observed residing in the same room with no	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 13	S9999		

barrier or any Transmission Based Precautions in between the residents.

The Facility Line List documents R50 tested positive for Covid-19 on 1/7/22 and R51 tested negative. The Facility Census Detail Reports dated 1/7/22, 1/8/22, 1/9/22, and 1/11/22 document R50 and R51 are roommates. On 1/12/22 at 12:40 PM R50 and R51 were observed still residing together in the same room with no Transmission Based Precautions between the residents. The Facility Line List documents R51 tested positive for Covid-19 on 1/12/22. On 1/13/22 at 8:00 AM, V2 (Director of Nursing) stated V2 said on 1/12/22 at around 6:30 PM the residents were rapid tested and R51 tested positive for Covid-19.

On 1/13/22 at 8:00 AM, V2 (Director of Nursing) stated all residents that had not previously tested positive for Covid-19 were tested on 1/7/22, 1/10/22, 1/12/22 by rapid tests at the facility. On 1/7/22 R50 tested positive and R51 tested negative for Covid-19.

On 1/13/22 at 10:50 AM, V21 (Social Service Director) stated the test results from 1/12/22 showed that R51 was also positive for Covid-19. Both residents remained roommates from the time that R50 was known to be Covid-19 positive from test results of 1/7/22 through 1/13/22.

2B.) On 1/11/22 at 10:30 AM, R32 and R33 were observed residing in the same room with no barrier or Transmission Based Precautions in place between the residents.

The Facility Line List documents R32 tested positive for Covid-19 on 1/10/22. The Facility Census Detail Report dated 1/11/22 documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 14 R32 and R33 are roommates. On 1/11/22 at 11:00 AM, V2 (Director of Nursing) stated all residents that had not previously tested positive for Covid-19 were tested on 1/10/22 by rapid tests at the facility. R32 tested positive and R33 tested negative for Covid-19. R32 and R33 were separated on 1/13/22. 2C.) On 1/11/22 at 11:25 AM and on 1/12/22 at 1:05 PM, R61 and R71 were observed residing in the same room with no Transmission Based Precautions between the residents. The Facility Line List documents R61 tested positive for Covid-19 on 1/7/22. The Facility Census Detail Report dated 1/7/22 documents R61 and R71 are roommates. On 1/11/22 at 11:00 AM, V2 (Director of Nursing) stated all residents that had not previously tested positive for Covid-19 were tested on 01/7/22 by rapid tests at the facility. R61 tested positive and R71 tested negative for Covid-19. The Facility Bed Census dated 1/7/22, 1/8/22, and 1/12/22 document R61 and R71 were roommates. The Facility Census Detail Report dated 1/11/22 document R61 and R71 were roommates. R71's Electronic Health Record's Progress notes documents: on 1/8/2022 at 1:13 AM, R71 had complaints of increased shortness of breath, inspiratory and expiratory wheezes, a productive cough and pain with breathing. On 1/8/22 at 10:26 AM R71's Progress Notes document: continue monitoring of R71 due to roommate (R61) positive for Covid-19, wheezing bilaterally, an occasional cough and congestion present. On 1/9/22 at 2:19 PM R71's Progress Notes document: R71 has a fever of 100.8 degrees	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 15 Fahrenheit, has complaints of chest pain, back pain and pain radiating down left arm. R71's Covid-19 rapid test is negative. Orders are given for R71 to be sent to the Emergency Room for evaluation. On 1/9/22 at 10:43 PM, R71's progress notes document R71 continues on isolation due to R71's roommate (R61) has tested positive for Covid-19. R71's lungs are clear. R71 has an occasional cough and congestion present. On 1/12/22 R71's progress note documents: R71 is noted with a wet productive cough, lungs are coarse, and complaints of chest hurting when coughing. The Facility Bed Census dated 1/9/22 documents: R71 returned from the hospital to R71's previous room. The Facility Bed Census dated 1/9/22 documents R61 and R71 are roommates. 2D.) On 1/11/22 at 11:22 AM, R26 and R27 were observed residing in the same room with no barrier or Transmission Based Precautions in place between the residents. On 1/11/22 at 12:52 PM, R26 was observed and heard coughing multiple times, while roommate R27 stated "I don't feel well." The Facility Line List documents R26 tested positive for Covid-19 on 1/10/22. The Facility Census Detail Report dated 1/11/22 documents R26 and R27 are roommates. On 1/11/22 at 11:00 AM, V2 (Director of Nursing) stated all residents that had not previously tested positive for Covid-19 were tested on 1/10/22 by rapid tests at the facility, R26 tested positive and R27 tested negative for Covid-19. On 1/12/22 at 10:00 AM, R26 and R27 were observed still residing in the same room with no Transmission Based Precautions in place	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 16	S9999		

between the residents. The Facility Census Detail Report dated 1/12/22 documents R26 and R27 were roommates. R26 and R27 were separated on 1/13/22.

The Facility Line List documents R27 tested positive for Covid-19 on 1/14/22 via a rapid test.

2E.) On 1/13/22 at 10:05 AM, R20 and R21 were observed residing in the same room with no Transmission Based Precautions in place between the roommates.

The Facility Line List documents R20 tested positive for Covid-19 on 1/12/22 and R21 tested negative for Covid-19.

On 1/11/22 at 11:00 AM, V2 (Director of Nursing) stated all residents that had not previously tested positive for Covid-19 were tested on 1/12/22 by rapid tests at the facility, R20 tested positive and R21 tested negative for Covid-19.

On 1/13/22 at 12:25 PM, R20 and R21 were observed residing in the same room with no Transmission Based Precautions in place between the roommates.

On 1/13/22 at 12:25 PM V36 (Certified Nurse Aide) stated, she was not sure if R21 or R20 would be separated since R20 tested positive for Covid-19 and R21 is still negative for Covid-19. V36 (CNA) stated, V21 (Social Services) would have that information.

The Facility Census Detail Report dated 1/12/22 documents R20 and R21 are roommates.

On 1/13/22 at 3:00 PM, R20 would not answer when spoken to. R20 had a brown tinged sputum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 17	S9999		

accumulating on R20's shirt while coughing, while residing with a covid-19 negative roommate (R21). There were no Transmission Based Precautions in place between the roommates.

On 1/13/22 at 4:10 PM, R20 (Covid-19 positive) and R21 (Covid-19 negative) were observed still residing in the same room with no Transmission Based Precautions in place between the roommates.

On 1/13/22 at 4:00 PM, V21 (Social Services) stated, R20 did test positive in the testing done on 1/12/22 at approximately 6:30 PM. She believes R20 and R21 might be separated and R21 moved over to the wing that they are going to make into the Covid-19 negative unit later this evening. She believes they are going to move the residents that have not tested positive for Covid-19 to the empty hall just past the business offices, the 100 hall. V21 stated, R23 is also Covid-19 negative. R23 is on the hall after the locked doors which does contain all Covid-19 positive residents, but R23 is on transmission-based precautions for something besides Covid-19, therefore she is unaware if they are going to move R23 or not.

3.) On 1/11/22 at 1:33 PM V2 (DON/the Infection Preventionist) said that all staff get fit tested for the N95 masks in use. V2 stated staff are to wear N95 masks and eye coverings when inside the facility. V2 stated proper N95 mask placement includes wearing one strap higher and one strap around the neck to make a secure fit and tight seal. You should see the mask move in and out when you breathe. V2 said she retrained the staff last week.

On 1/11/22 at 1:33 PM during the interview with V2 (DON), two staff were observed walking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 18 between surveyors and V2 (DON) with masks improperly worn. V31 (Housekeeping) had the second strap of the N95, in front of the N95 hanging loose, and V29 (CNA/Transportation) had the bottom strap of the N95 completely cut off. V2 did not address it at that time. On 1/11/22 at 10:25 AM, V31 (Housekeeping) and V29 (CNA/Transportation) were observed walking down the hall with their N95 incorrectly. V31 (Housekeeping) had the bottom strap of his N95 hanging down in front of his N95 with the strap hanging below his chin and V29 (CNA/Transportation) had completely removed the bottom strap of her N95, causing neither N95 not to fit securely. On 1/11/22 at 10:27 AM, V31 (Housekeeping) was observed entering R15's (Covid-19 positive) room wearing his mask with the bottom strap hanging loose in front of the N95, not creating a tight fit. On 1/11/22 at 1:33 PM, V10 (Certified Nurse Aide) was observed not wearing her N95 correctly, both straps were at the bottom of her neck with the mask fitting very loosely. V10 had to keep pulling it up with her hands, touching the front of it. V10 had just exited R4's room, a Covid-19 positive resident. V10 (CNA) then touched the wall, a table sitting in the hallway and a trash bag never performing hand hygiene after touching the front of her N95 or before touching any of the other items. On 1/11/22 at 12:55 PM, V10 (CNA) was seated at a table in the hallway with her mask pulled down below her nose. V10 did not pull up her mask immediately when surveyor began speaking with her.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 19 On 1/11/22 at 1:30 PM, V10 was observed going in and out of resident rooms collecting disposable plates from lunch for disposal. V10 was observed not changing her N95 mask while going in and out of resident rooms or cover the N95 mask with surgical masks. V10 said that she was not sure which rooms were Covid positive and which rooms were not and indicated that she was confused about how to remove the disposable dishes from the resident rooms properly. V10 (CNA) stated, there had been some infection control training, but so many residents became Covid positive in such a short time, it has been confusing. On 1/11/22 at 1:33 PM, V10 (Certified Nurse Aide) stated she does not always put a gown on when she enters the resident's rooms. If there is a gown already hanging there, she will put it on. V10 (Certified Nurse Aide) stated she is only going in and grabbing their dishes from lunch. V10 (Certified Nurse Aide) stated she does not know which rooms have Covid-19 positive residents and which ones do not. On 1/11/22 at 11:00 AM, V24 (CNA) was wearing her N95 appropriately with the bottom strap hanging down in front below her chin, not making a seal prior to entering R4's room (Covid-19 positive) and after exiting R4's room. V24 (CNA) then walked down the hall and enter R20's (Covid-19 negative) room. On 1/11/22 at 12:36 PM, V19 (Activity Director) entered R44's room, a Covid-19 positive resident. V19 did not exchange her N95 mask upon exiting the room, on a hallway that contain both Covid-19 positive and negative rooms. V19 did not use a surgical mask to cover the N95 mask when in	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 20 R44's room. On 1/11/22 at 3:40 PM, V19 (Activity Director) donned PPE and brought activity items (puzzles, magazines, and a deck of cards) into R48's, a Covid-19 positive resident and R49's, a Covid-19 positive resident, room. V19 doffed all but N95 mask upon exit from room. V19 (Activity Director) did not use a surgical mask to cover the N95. Signage present on R48 and R49's door that read: Contact/Droplet Precautions. On 1/12/22 at 12:25 PM, V27 (Speech Language pathologist) was observed in R30's room (Covid-19 positive) wearing his N95 with the bottom strap hanging down in front under his chin not creating a seal. V27 (Speech Language Pathologist) left R30's room and entered R34's room (Covid-19 negative) then started doing therapy with R34. V27 never secured his N95 properly between rooms, allowing it to hang loosely. On 1/12/22 at 3:05 PM, R35's door had a used gown that had been worn into a Covid-19 positive room, rolled vertically with the top approximately eight inches tucked into the infection control supply kit hanging over the door and the rest of the gown hanging over the lower half of the infection control supply kit touching the clean PPE stored in the infection control supply holder, contaminating the items in the holder. Then on 1/12/22 at 3:35 PM, V19 (Activity Director) was pushing her cart and supplies down the hall to do one to one activities with the residents. She stopped her cart in front of a room. V19 walked down to the infection control supplies kit hanging on R35's door and pulled some gloves out of one of the pockets and two gowns out of another pocket. V19 walked back to her cart and laid the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 21 gloves and gowns on top of her supplies. On 1/13/22 at 11:20 AM, V30 (Dietary) went into R24 (Covid-19 positive) and R25's (Covid-19 positive) room with a N95 and gloves on. V30 obtained their drink orders and came out to the beverage cart in the hallway. V30 prepared the chosen beverages and went back into R24 and R25's room to deliver the drinks. While making the drinks, V30 touched the cooler, drink pitchers, the cart, and handle on the coffee dispenser. V30 then entered R26 (Covid-19 positive) and R27's (Covid-19 negative) room getting their drink orders and coming back out into the hallway to prepare the drinks. V30 then entered R28 and R29's room (Covid-19 negative residents) getting their drink orders, coming back out to the drink cart, preparing the drinks, and taking the drinks back into their room. V30 then entered R32 (Covid-19 negative) and R33's (Covid-19 positive) room, obtained their drink order, came out to the cart, prepared their drinks and took them into their room for them. V30 then entered R13 and R14's room (both Covid-19 negative residents) obtained their drink orders, came out to the cart, prepared their drinks and took the drinks into their room. V30 did not perform any hand hygiene or PPE change between any of the rooms (some housing Covid-19 positive residents and some housing Covid-19 negative residents), between touching the items on the beverage cart, or before taking the drinks back into the resident's rooms. All rooms housing Covid-19 positive residents had signage present to indicate Contact/Droplet Precautions and that PPE should be worn when entering the room and hand hygiene should be performed after doffing PPE. V30 then took the beverage cart, with soda and juices still on it (that had been touched with the same gloves that she went into the Covid-19	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 22	S9999		

positive rooms with) to the dining room and left unattended next to a refrigerator.

On 1/13/22 at 12:50 PM, V27 (Speech Language Pathologist/SLP) was observed in R34's room, sitting within two feet of R34 (Covid-19 negative), with his N95 on with the bottom strap not in place, hanging below his chin, and not forming a seal. V27 had just left R52's (Covid-19 positive) room, without securing his N95 or any N95 change.

On 1/13/22 at 1:10 PM V28 (Physical Therapy Aide/PTA) was performing therapy with R32 (Covid-19 positive) in his room wearing her N95 the with the bottom strap hanging loose in front of the N95, under her chin, not forming a seal.

On 1/13/22 at 9:45 AM, V29 (CNA/transportation) was assisting moving Covid negative residents to the new negative hall wearing her N95 with the bottom strap cut off, causing the N95 not to have a seal.

On 1/13/22, at 12:20 PM, V26 (Activities Assistant) entered the room of R38 (Covid positive) at 12:20 PM. R38 had signage for Contact/Droplet Precautions outside of R38's door. R38 was heard repeatedly coughing during this time was not wearing a mask when V26 was in R38's room. The facility's Line List documents that R38 tested positive for Covid-19 on 1/7/22. Immediately after, on 1/13/22 at 1:00 PM, V26 entered the room of R12, who was Covid-19 negative when tested on 1/12/22. Then, on 1/13/22 at 1:05 PM, V26 entered the room of R2, who had also tested negative on 1/12/22. On 1/13/22 at 1:20 PM, V26 entered the room of R31, who had tested positive for Covid-19 on 1/7/22 as documented on the facility's Line List. There was signage for Contact/Droplet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 23 Precautions outside of R31's door. R31 was heard repeatedly coughing during this time and was not wearing a mask when V26 was inside of R31's room. On 1/13/22 during V26's visits with R38, R12, R2, and R31, V26 used a rolling chair that she brought inside each of these 4 rooms during 1:1 activity sessions and had a cart full of activity items that she left outside of each room. During visits to these residents' rooms, V26 used the same N95 without a surgical mask cover. V26 did not sanitize the rolling chair between resident rooms or dispose of her mask and obtain a new N95 mask prior to each resident visit. V26 sat less than 3 feet from R38, R12, R2, and R31 during the length of these activities and was not observed to ask residents to use their masks. On 1/13/22 at 1:30 PM, on the second floor, R39 walked out from behind the plastic entry of R39's room, without a mask, holding R39's large drinking cup and loudly said that she needed something to drink. The facility Line List documents that R39 tested Covid-19 positive on 1/7/22. There was signage outside of R39's room for Contact/Droplet Precautions. V26 rushed down the hall to verbally encourage R39 to return to the chair inside of R39's room. V26 took R39's contaminated cup without wearing gloves and told R39 she would get ice and a beverage. V26 stopped near the surveyor on her walk to the ice chest and stated, "I'm so confused. I don't know what to do! Was that the right thing to do?" V26 said that she was frustrated and unsure of how to avoid cross contamination. V26 walked to the ice chest with the contaminated plastic cup and touched the ice scoop, the lid to open the ice chest, and the refrigerator door, all while touching the plastic cup she received from the Covid-19 positive resident. V26 used hand sanitizer from a wall dispenser after handing the cup and canned	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 24 beverage to R39 through the plastic at the door. V26 potentially contaminated the ice scoop, the lid to the ice chest, and the refrigerator door handle. On 1/18/22 at 10:10 AM, V24 (CNA) was wearing her N95 with the second strap in front, below her chin, not creating a seal prior to entering R29's (Covid-19 negative) room. On 1/18/22 at 10:35 AM, V31 (Housekeeping) was observed in R27's room, a Covid-19 positive resident. V31 left R27's room with his contaminated PPE on, walked down the hall to the supply closet, touched the door handle and supplies in the closet, then walked back down the hall to his cart, touching his cart, never doffing his PPE or performing hand hygiene. 4.) On 1/18/22 at 11:15 AM, V31 (Housekeeping) stated he does not know the names of the cleaners he uses but knows where the bottles are. V31 does not know the contact times for the cleaners either. He just wipes the items off, mops the floor, and when it is dry, he moves the sign to the next room. V31 stated, he guesses the contact time would be a minute or two. V31 walked down to the closet and picked up the cleaner. V31 stated, the cleaner he wipes items off with is Brand name cleaner A and the cleaner he uses on the floor is Brand name cleaner B. V31 stated, he changes gloves between rooms, but he has not been told when to change his gown and he does not change his mask. Brand name cleaner A has a contact time of 10 minutes, (the United States Environmental Protection Agency Pesticide Registration, Disinfectants for Coronavirus (Covid-19)). Brand name cleaner B is not an EPA N listed cleaner,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 25 from the United States Environmental Protection Agency Pesticide Registration, Disinfectants for Coronavirus (Covid-19) www.epa.gov/listN. On 1/18/22 at 11:50 AM, V40 (technical service representative) stated, Brand name cleaner B is neutral cleaner and is not approved by the EPA as a N listed cleaner. On 01/25/22 at 2:45 PM, V15 (Environmental Services Supervisor) stated, he is the housekeeping, laundry, and dining supervisor. V15 stated, that staff should be donning PPE, including a gown, gloves, eye protection and N95 when going into any resident's room that is Covid-19 positive or have any transmission-based precautions. The PPE should be doffed upon exiting the room. The PPE should be changed between every room and disposed of after each use. Staff should not walk down the hallway with PPE on after exiting from a Covid-19 positive resident's room. N95's should be worn with the top strap higher up on the back of the head and the bottom strap lower on the back of the head, closer to the neck, so that the N95 makes a seal. The N95 should be changed between rooms or a surgical mask put over the N95 and the surgical mask doffed upon exiting the resident's room. The staff receive ongoing training from him when he notices an issue and receive monthly training from V17 (RN/staff development). The disinfectants that should be used are: Germicidal bleach cleaner (EPA 56392-7), Brand name cleaner C, bleach (EPA 67619-32), Brand name cleaner B, Brand name cleaner A, and Bleach Germicidal wipes (EPA 67619-12). The Facility Policy titled, "Infection Control" dated 04/24/2014, with a revision date of 01/27/2021	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 26 states, ..,...IV. ENVIRONMENT: Housekeeping procedures will be conducted in keeping with the infection control procedures to reduce the spread of infections. 2. Surfaces are cleaned with a disinfectant/germicidal solution mixed per manufacturer's instructions ....8. Hallway handrails, doorknobs, etc. are wiped with a disinfectant and maybe followed up with a disinfectant spray. A Covid 19 Policy dated 03/09/20 documented, "Human Coronavirus is most commonly spread from an infected person to others through...Air by coughing and sneezing...close personal contact... (and/or) Touching an object or surface with the virus on it..,,If a resident shows symptoms (of Covid), (Begin) droplet precautions, (and)(move) them to an isolated room... Any resident who has tested positive will quarantine for 14 days...During this time, each resident will be watched and supported for any additional emotional needs. The Facility policy titled, " Subject Coronavirus (Covid 19) dated 03/09/20 with a revision date of 10/01/21 states, Policy: A new respiratory illness - Coronavirus (Covid-19) is spreading globally and there have been instances of COVID-19 community spread in the United States. This facility will join general strategies recommended by the Center for Disease Control (CDC), federal, state and local health institutes to prevent the spread of COVID-19 in Long Term Care Facilities. Transmission - Human coronaviruses most commonly spread from an infected person to other through: air by coughing and sneezing, close personal contact, such as touching or shaking hands, touching an object or surface with the virus on it, then touching our mouth, nose, or eyes before washing your hands ...Symptoms -	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 27 Clinical features are fever or sign/symptoms of lower respiratory illnesses. May include: Fever, Cough, Shortness of breath, Sore throat, Chills or shaking, Muscle Pain/extreme weakness, Headaches, Loss of taste or smell, Human coronaviruses can sometimes cause lower-respiratory tract illnesses, such as pneumonia or bronchitis. Facility Approaches: Monitor residents at least once per nurse shift .... for fever or respiratory symptoms. Assessments and vital signs will be subject to change as need develops. ....In general for care of residents with undiagnosed respiratory infection use Standard, Contact and Droplet precaution with eye protection ....We will follow our isolation precaution format for droplet respiratory care. The Facility Policy titled Subject: Infection Control dated 04/24/2014 with a revision date of 01/27/2021 states: ...Standard precautions .....Gloves ....change gloves are changed as needed: between tasks and procedures ....Remove gloves promptly after use, before touching non-contaminated items or surface. Hands hygiene is required immediately after glove removal. Gloves will also be worn, but not limited to: gloves are worn when in direct contact with a resident who is infected or colonized with organisms that are transmitted by direct contact. ...when handling ..... items that may be contaminated ....Gowns ...if in isolation, gowns should be removed and placed in hamper in room ...Face mask/eye and face protection ....face mask will be designated according to incident e.g. surgical, cloth, or KN95 or N95. Hand hygiene: all staff will perform hand hygiene as recommended by the CDC, and/or the CMS state operations manual to prevent the transmission of infection causing organisms ....Environment: ....surfaces are cleaned with a disinfectant/germicidal solution	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 28 mixed per manufacturer's instructions .... Isolation Precautions: Isolation precautions are in addition to standard precautions and are used for residents who are known to be infected with infectious agents that require additional control measures to prevent transmission to other residents ...2..arrange to transfer resident to a private room with a private bath if available. Transfer only clothing and personal items needed for period of isolation. 3. If a private room with a private bathroom is not available, residents with the same type of infection may cohort ..... Airborne / Droplet Precautions: Airborne precautions reduce the transmission of organisms that remain suspended in the air. This precaution will be used for individuals with documented or suspected infection with microorganisms transmitted by droplets (large or small droplets) which can be passed by the individual coughing, sneezing, talking, ...2. resident is to be placed in a private room if possible. 3. Staff must wear mask and gloves upon entering room. 6. Dedicate the use of vital sign equipment, lift pads or belts to individuals in isolation. 7. Trash should be maintained in the room and discarded at the end of each shift or when it is full. Contact Precautions: Contact precautions reduce the transmission of organisms that are spread with person -to-person contact. 1. Refer to standard precautions. 2. Refer to contact isolation policy. How to Properly Put on and take off a disposable respirator: ...The top strap goes over and rests at the top back of your head. The bottom strap is positioned around the neck and below the ears ....Checking your seal ...place both hands over the respirator, take a quick breath in to chick whether the respirator seals tightly to the face. Place both hand completely over the respirator	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 29	S9999		

and exhale. If you feel leakage, there is not a proper seal ....If air leaks at the mask edges, re-adjust the straps along the sides of your head until a proper seal is achieved. www.cdc.gov/niosh/docs.

The non-dated article titled "6 steps for Safe & Effective Disinfectant Use" Step 1: check that your product is EPA approved. Find the EPA registration number on the product. Then, check to see if it is on the EPA's list of approved disinfectants at: epa.gov/listn. Step 2: read the directions- Follow the product's directions. Check "use sites" and "surface types" to see where you can use the product. Read the "precautionary statements." Step 3: Pre-clean the surface - Make sure to wash the surface with soap and water if the directions mention pre-cleaning or if the surface is visibly dirty. Step 4: Follow the contact time - You can find the contact time in the directions. The surface should remain wet the whole time to ensure the product is effective. Step 5: Wear gloves and wash your hands - For disposable gloves, discard them after each cleaning. For reusable gloves, dedicate a pair to disinfecting Covid-19. Wash your hands after removing the gloves. Step 6: Lock it up - Keep lids tightly closed and store out of reach. Coronavirus.gov
The EPA list of approved disinfectants at epa.gov/listn document Germicidal bleach cleaner (EPA 56392-7) documents a contact time of one minute, Brand name cleaner C documents a contact time of ten minutes, bleach (EPA 67619-32) documents a contact time of five minutes, Brand name cleaner B, is not an EPA listed disinfectant, Brand name cleaner a documents a contact time of ten minutes, and Bleach Germicidal wipes (EPA 67619-12) documents a contact time of one minute.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 30 "A" Statement of Licensure Violations III. of V. 300.610 a) 300.1210 a) 300.1210 b)4)5) 300.1210 d)3)6) 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 31 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. b) The facility shall provide the necessary care and 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. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 32	S9999		

determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on interview, record review, and observation, the facility failed to implement and use effective progressive interventions needed to prevent falls and maintain mechanical lift equipment in a safe, working condition for 2 of 3 residents (R1, R2) reviewed for fall in a sample of 71.

Findings include:

1. On 12/30/21 at 9:30am, V6 (family member of R2) stated that R2 has sustained several falls while living at the facility. V6 stated she does not believe the facility is attempting to add interventions which will prevent R2 from falling. V6 stated, "I know they have told (R2) that (R2) needs to use (R2's) call light if (R2) wants something, instead of (R2) trying to get up on (R2's) own, but (R2) is extremely confused and there is no way (R2) can remember to do that."

R2's Minimal Data Set (MD) dated 12/9/21 documents R2's Brief Interview for Mental Status (BIMS) as a 99, meaning R2 is unable to complete the interview. It also documented that R2 has a score of 3 under Cognitive Skills for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 33 Daily Decision which means R2 is severely impaired. R2's current care plan under Focus dated 4/29/19 documents: Cognitive, "I have problems with short- and long-term memory. At times I lack cognitive skills that I need to make daily decisions. My Alzheimer's Disease/Dementia has caused my memory to fail at times." Accident Investigation Reports for R2 documented the following: 6/11/21: Resident found on floor beside bed, unwitnessed fall. No apparent injuries. Corrective action taken/Measures to prevent recurrence: Ensure regular (bowel and bladder) checks, increase visual checks, ask resident after meals if R2 wants to stay in bed. 8/5/21: Resident found on floor in front of wheelchair, unwitnessed fall. Injuries: Skin tear, bruising. Corrective action taken/Measures to prevent recurrence: Help resident to bed right after supper, increase visual checks. 8/23/21: Resident (was) seen leaning over in wheelchair, fell out headfirst, witnessed fall. Injuries: Skin tear to left hand, sterile strips and dressing applied. Corrective action taken/Measures to prevent recurrence: (Medical) treatment, encourage resident to use call light. 9/13/21: Resident was in the dining room and had finished eating, CNAs (Certified Nursing Assistants) were taking residents back to their rooms. Nurse was down YYY hall passing medications. Resident pulled chair opposite to where R2 was sitting then used the doorway by the ice machine to pull self and R2's (wheel) chair	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 34	S9999		

into the doorway and down the small incline, (causing) the chair to dump R2 out into the floor. No apparent injuries. Contributing factors: No CNA present in the dining room.
Corrective action taken/Measures to prevent recurrence: Educate CNAs on the fact that one of the CNAs are to stay in the dining room with the resident until the dining room is empty.

10/16/21: Unwitnessed fall, resident found lying on the floor on R2's right side. Injuries: Two lacerations. Corrective action taken/Measures to prevent recurrence: Reminders to use call light and only transfer with assistance.

12/15/21: Resident was found tipped over face first in R2's wheelchair, unwitnessed fall. No apparent injuries. Corrective action taken/Measures to prevent recurrence: Encourage use of call light, do not leave resident in wheelchair in room alone.

12/20/21: Resident tipped (specialized reclining wheelchair) forward, witnessed fall. Injuries: Bruising. Corrective action taken/Measures to prevent recurrence: Close monitoring when sitting in (wheelchair).

12/27/21: Resident found on floor by bed. Injuries: Small skin tear to right side of the neck. Corrective action taken/Measures to prevent recurrence: Continue frequent visual checks, re-educate on use of call light.

1/1/22: Found sitting on safety mat by R2's bed, unwitnessed fall. Bowel movement on groin and bottom. No apparent injuries. Corrective action taken/Measures to prevent recurrence: More frequent safety checks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 35 R2's Care Plan with a review date of 12/27/21 documented a problem area, "I have a potential for falls or injury from falls." The following interventions were documented: 9/13/21: Staff to ensure proper placement in (wheel) chair. 10/16/21: Staff to ensure proper placement in wheelchair with sensor pad in place. 12/15/21: Ensure he is properly positioned (in wheelchair) and place by the nurses' station or recliner after meals. 12/20/21: Ensure proper positioning in wheelchair, and medication review (to be done). The Care Plan did not include interventions for the 8/5/21, 8/23/21, 12/27/21 and 1/1/22 falls. On 1/4/22 at 1:00pm, after lunch, R2 was observed alone in R2's room sitting up in R2's specialized reclining wheelchair. R2 was alert but either would not/could not answer the surveyor's questions or answered them unintelligibly. R2's call light was sitting in R2's lap. The surveyor showed R2 the call light and asked R2 to push the button, but R2 looked confused and was unable to comply with the request. On 1/4/22 at 1:10pm, V9 (Licensed Practical Nurse) stated R2 is generally unable to activate R2's call light. V9 stated R2's fall prevention interventions include putting R2's bed in the lowest position, placing a fall mat beside the bed, a pad alarm while in R2's wheelchair, placing R2's room closest to the nurses' station, and visually checking on R2 every 30 minutes. V9 stated she was unaware of the intervention stating R2 should be placed in R2's recliner after lunch.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 36 On 1/4/22 at 1:20pm, V10 (Certified Nursing Assistant) stated she was not sure what R2's fall precautions are, but she would check R2's chart. On 1/4/22 at 1:30pm, V10 stated R2's fall precaution is for R2 to be checked on every time staff walk by R2's room. V10 stated she is not aware of an intervention for R2 to be placed in R2's recliner after lunch. On 1/6/22 at 10:15am, V16 (Licensed Practical Nurse Care Plan Coordinator) verified that no fall interventions were added to the Care Plan following the 8/5/21, 8/23/21, 12/27/21 and 1/1/22 falls. V16 confirmed that R2 is unable to use R2's call light. V16 confirmed that several of R2's falls have occurred while sitting in R2's specialty wheelchair. When asked if R2 could benefit from a Physical Therapy evaluation regarding the use of this chair, V16 stated it had not occurred to her, but she could schedule that. On 1/6/22 at 10:30am, V1 (Administrator) stated that following R2's 9/13/21 fall, CNA staff were in-serviced that at least one should remain in the dining room until residents are finished with the meal. 2. On 1/4/22 at 8:35am, R1, who was alert and oriented to person, place, time, and purpose, stated that on 12/11/21, CNA staff were lifting R1 into bed with a mechanical lift device. R1 stated as R1 was being lowered down onto the bed, two of the straps broke and R1's legs were suddenly released onto the side of the bed. R1 stated staff told R1 the straps were old and in need of replacement. R1 stated after the incident R1 had back pain which caused R1 to have to go to the emergency room (ER) on 12/13/21. R1 stated no physical injuries were found at the ER, but R1 was emotionally distraught by the incident.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 37 An Accident Report dated 12/11/21 documented, "Two staff members were putting the resident to bed, all snaps were securely strapped and as resident was slowly raised into the air, resident's upper body from thighs to head were raised over the bed, both leg straps broke and resident was placed on bed, from knees to feet, were hanging off the bed. Staff picked up legs and put them back on the bed. (Resident) now complaining of back pain." On 1/4/22 at 2:20pm, V2 (Director of Nurses) stated that after the above incident, she did an immediate inventory of all mechanical lift straps and discarded any that were worn. V2 stated that on 12/28/21, nursing staff were in-serviced that mechanical lift should be checked prior to each transfer, and staff should let administration know when worn straps are discarded so more can be ordered. An undated Mechanical Lift Transfer Policy stated, "Slings will be checked by the laundry department with each washing and (by) nursing staff on the floor prior to use, for any defects or malfunctions." An undated Safety and Supervision of Residents Policy stated, "Our facility strives to make the environment as free from accidents as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities...The care team shall target interventions to reduce individual risks related to hazards in the environment including adequate supervision and assistive devices...Monitoring the effectiveness of interventions shall include..evaluating the effectiveness of interventions..modifying or replacing interventions	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 38 as needed..(and) evaluating the effectiveness of new or revised interventions." "B" Statement of Licensure Violations IV. of V. 300.610 a) 300.1210 b)3)4) 300.1230 e) 300.1230 f) 300.2070 a) 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 b) The facility shall provide the necessary care and 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. 3) All nursing personnel shall assist and encourage residents so that a resident who is	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 39 incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. Section 300.1230 Direct Care Staffing e) The facility shall schedule nursing personnel so that the nursing needs of all residents are met. f) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs per day. Section 300.2070 Scheduling Meals a) A minimum of three meals or their equivalent shall be served daily at regular times with no more than a l4 hour span between a substantial evening meal and breakfast. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 40	S9999		

review, the facility failed to answer call lights in a timely manner to promote dignity for 4 residents of 11 residents (R1, R2, R9, R10). The facility failed to provide sufficient staff to meet the residents' needs safely and in a timely manner. This has the potential to affect all 74 residents living in the facility.

Findings include:

1. On 12/30/21 at 9:30 AM, V6 (family member of R2 stated she does not believe the facility is adequately staffed to meet the residents' needs. V6 stated she visits R2 several times per week and has observed that when she activates R2's call light, it often takes in excess of 30 minutes for staff to respond. V6 stated she has observed breakfast being served late on several occasions as there are not enough CNA (Certified Nursing Assistant) staff available to get residents up and dressed and into the dining room. V6 stated on occasion when she has visited, residents have still been in the dining room eating at 10am. V6 stated she is not so much concerned about breakfast being late, but the fact that it shows how short staffed the facility is.

On 1/2/22 at 7:45 AM, V5 (Registered Nurse) stated breakfast is served between 8:00 to 8:30 AM.

On 1/2/22 at 8:25 AM, there were five residents seated in the second-floor dining room, with none having been served. On 1/2/22 at 8:45 AM, steam tables with food were observed in the dining room, ready for service, with V11 (Dietary staff) standing by.

On 1/2/22 at 9:00 AM, V3 (Licensed Practical Nurse/LPN) was observed waking R2 up and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 41 getting R2 dressed. V3 states meals are chronically late on the weekend due to not having enough staff to get people up. V3 stated breakfast is to start at 8:00 AM but on weekends it never happens, and sometimes they just get done with breakfast when it's time for lunch. On 1/2/22 at 9:10 AM, all residents already in the dining room had been served and were eating. At 9:20 AM, V3 brought R2 into the dining room, and R2 was served by 9:23 AM. V11 was observed sending out the first cart of hall trays for breakfast at 10:00 AM. At 10:15, R2, the only resident remaining in the dining room, was wheeled out. On 1/2/22 At 10:20 AM, V11 stated when meals are late, it is due to there not being enough CNA staff to get people up and into the dining room on time. V11 stated breakfast is to begin at 8:00 AM. 2. On 1/4/22 at 8:35 AM, R1 was alert and oriented to person, place, time, and purpose. R1 had a large wall clock within view of R1's bed. R1 stated the facility is understaffed, especially on weekends. R1 stated this results in breakfast being late, and call lights routinely taking at least 30 minutes for a response, especially in the evening and on nights. R1 stated R1 has frequently had urine and bowel accidents in the bed while waiting on the call light. R1 stated sometimes staff come in and turn the call light off and never come back. R1 stated on the evening of 12/26/21, R1's call light was in floor out of reach, R1 needed to go to the bathroom, and had to yell for help for 30 minutes before anybody came. R1's Minimum Data Set (MDS) dated 10/28/21 documented that R1 requires extensive assistance from at least two staff for transfers	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 42 and toileting. 3. On 1/4/22 at 11am, R9 was alert and oriented to person, place, time and purpose. R9 had a large wall clock within view of R9's bed. R9 stated call lights almost always take at least 30 minutes for a response, especially in the evening and overnight hours. R9 stated R9 has had urine and bowel accidents while waiting on the call light. R9 stated the facility is short staffed and it's not unusual for meals to be late as staff have difficulty getting everybody up and around. R9 stated these issues are a frequent topic at Resident Council meetings. R9's MDS dated 12/13/21 documented that R9 requires extensive assistance from at least two staff members for transfers and toileting. 3. On 1/4/22 at 11:45 AM, R10 was alert and oriented to person, place, time, and purpose. R10 had a large wall clock within view of R10's bed. R10 was noted to be a bilateral above the knee amputee. R10 stated that last week in the evening, R10 had been incontinent of bowel and bladder and activated R10's call light. R10 stated a CNA responded and said she would be back soon. R10 stated R10 sat in urine and feces for 2 hours until somebody came back in. R10 stated this has happened many times before. R10 stated R10 knows R10 is at risk for skin breakdown and is concerned about being left wet and soiled. R10 stated anytime R10 complains, the CNA's say they are understaffed. R10's 12/13/21 MDS documented that R10 is totally dependent on at least two staff members for transfers and requires extensive assistance from at least two staff members for toileting.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 43 On 1/4/22 at 10:15 AM, V7 (Ombudsman) stated she has heard recent complaints from R1, R9, and R10 about short staffing causing long call light wait times. Resident Council Meeting Minutes dated 10/28/21 documented, "Residents would like for the CNAs to stop turning off the call light and saying they will be back in a minute and then not returning." 4. An Accident Investigation Report dated 9/13/21 documented: "(R2) was in the dining room and had finished eating, CNAs (Certified Nursing Assistants) were taking residents back to their rooms. Nurse was down YYY hall passing medications. Resident pulled chair opposite to where (R2) was sitting then used the doorway by the ice machine to pull self and (R2's) (wheel) chair into the doorway and down the small incline, (causing) the chair to dump (R2) out into the floor. No apparent injuries. Contributing factors: No CNA present in the dining room." On 1/4/22 at 2:15 PM, V1 (Administrator) stated she is unaware of any issues with meals being served late. V1 stated call lights have not been audited for about two months, and when they were, no issues were noted. V1 stated she is unaware of any issues with long call light wait times. V1 stated the facility is adequately staffed. On 1/4/22 at 2:20 PM, V2 (Director of Nurses) stated she is new to the position, having started 12/9/21. V2 stated it is her expectation that call lights will be answered in less than 15 minutes. A Call Light Policy dated 11/30/21 stated, "Bedside call lights are to be placed within the residents reach when the resident is in the room...Staff should respond as promptly as	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 44 possible to a call light when it is activated." An Activities of Daily Living Policy dated March 2018 documented, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene...including appropriate support and assistance with...elimination(toileting)." An undated Resident Rights Policy documented, "All residents shall be permitted respect and privacy in their medical and personal care program." An undated Staffing Policy stated, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. ...Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each residents plan of care." On 1/11/22 at 11:00 AM, V2 (Director of Nursing/DON) stated, the document titled "Census Detail Report" dated 1/11/2022 documents the current census as 74, and the information on it is correct including room numbers. "B" Statement of Licensure Violations V. of V. 300.610 a) 300.1210 d)1) 300.1630 d) Section 300.610 Resident Care Policies	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 45 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 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. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to administer a blood pressure medication for 1 of 3 residents (R14) reviewed for medication administration in the sample of 71.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 46 Findings include: R14's Electronic Health Record documents R14 diagnoses including: Systolic Heart Failure, Anxiety Disorder, Long Term use of Anticoagulants, Major Depressive Disorder, Essential Hypertension, Allergic Rhinitis, Muscle Spasms, and Hyperlipidemia. R14's Minimum Data Set (MDS) Section C: Cognitive Patterns, dated 1/1/2022 documents a Brief Interview of Mental Status (BIMS) score of 13, which indicates R14 is cognitively intact. R14's Electronic Medical Record documents a Physician Order, renewed on 12/23/2021, for Bystolic 20 mg tablet, give 1 tablet once daily, every day at 8:00 AM. R14's electronic Medication Administration Record (MAR), dated January 2022, documents that Bystolic 20 mg was not administered on 1/9/22, 1/14/22 or 1/15/22. On 1/11/22 at 11:10 AM, R14 said R14 did not get the Bystolic medication the other day, and R14 takes 20 mg (milligrams) of Bystolic every day for R14's heart condition. R14 stated, R14 does not feel right when R14 does not get the medication. On 1/13/22 at 3:17 PM, R14 stated that R14's blood pressure has not felt right, and if R14 does not get the medication for blood pressure, R14 can feel that it is off. R14 said sometimes it can feel off for a day or two after not receiving the Bystolic medication. On 1/18/22 at 1:33 PM, V17 (Registered Nurse/RN) stated, R14 did not receive R14's Bystolic blood pressure medication on 1/9, 1/14,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 47 and 1/15/22. V17 stated, it was probably due to not having any of the medication on hand. V17 stated, there was none in the facility's "e kit" (Emergency Medication Kit). V17 stated, that R14 was not given anything else in its place, or that the physician had been called. V17 stated, she can see where R14's vitals were taken once a shift for three days, after receiving R14's booster for Covid-19, but that is all. On 1/18/22 at 2:55 PM, V2 (Director of Nursing/DON) stated, if (R14) did not get R14's medication because we did not have any, and the pharmacy could not get it here for the next dose, the doctor should have been called and (R14) should have been monitored for a medication that assists with blood pressure - R14's blood pressure should have been monitored more frequently. On 1/19/22 at 12:24 PM, V32 (Lead Consultant Pharmacist/Clinical Coordinator) stated, there was medication delivered for R14 on 1/15/22 and 1/17/22. The delivery dates on the shipping manifests confirm this information and document that six 10 mg pills of Nebivolol (Generic Bystolic) were delivered on the 1/15/22 at 12:03 AM, therefore the medication would have been present for the 1/15/22 dose. On 1/19/22 at 1:26 PM, V33 (Pharmacy Data Records) stated, he does not see the actual request for the medication (Bystolic), therefore the medication was probably called in. The orders are processed within 24 hours and the order was processed on the 1/14/22 at 7:00 PM. V33 stated, they do not have a medication request for 1/8/22 or 1/9/22, and they did not send any out on the 9th of January. V33 stated even if they did not have any in stock and had to send it from another	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 48	S9999		

pharmacy, they would have documentation of that request being sent to the other pharmacy. V33 stated the facility received the first shipment on 1/15/22 at 12:03 AM. A Delivery Manifest dated 1/15/22 documents that information.

On 2/1/22 at 11:47 AM V42 (Advanced Practiced Nurse/APN) stated, she was unaware R14 did not get Bystolic on 1/9/22, 1/14/22 or on 1/15/22. R14's blood pressure may have been elevated during that time but, she does not feel there would have been any other effects. She would have suggested they had monitored R14's blood pressure more closely during that time frame.

Facility Policy titled Subject: "Medication Therapy" (Therapy) dated 04/24/2014 with a revised date of 04/28/2021 states: Medication Orders: 1. Medications, both prescription and over the counter, shall be administered only upon the written order of a person with the license and authorization to prescribe such medications in this state. 3. Once orders have been received and carried through, appropriate medication will be ordered through the appropriate pharmacy service resident uses. 4. If the prescription is an over the counter medication, it will be dispensed through a stock supply or individual provided dispense source, depending on financial criteria. ....7. Physicians and LN will monitor ordered medications for continued indications, proper dosage, duration and possible adverse reactions. Refilling Medications: 1. This facility will follow their pharmacy service protocols with medication refills. .... 3. Staff will monitor refill needs and order appropriately for continuity. ... . Medication Administration: 1. Medications shall be administered in a safe and timely manner and as prescribed. .... Time Frame: 1. Medications must be administered in accordance with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001473	A. BUILDING: _____ B. WING _____	02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLYLE HEALTHCARE & SR LIVING	501 CLINTON STREET CARLYLE, IL 62231

(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) COMPLETE DATE
S9999	Continued From page 49 orders, including any required time frame. 2. Medications must be administered within one hour of their scheduled time (either one hour before or one hour after), Unless otherwise specified e.g.: before and after meal orders. .....Administration: .... 8. Check for any specific instructions e.g. : Blood pressure or pulse check prior to dispensing drug. Follow physician guidelines for Blood Pressure ...Administration of "PRN" or "As Needed" Medication 1. PRN medication are allowed as follows: ... ... b. If the resident is showing signs of need, the LN may confer with resident on availability and need. Note body language or actions. ... ...5. Documentation will be completed after administering medication in EMAR including, reason for Administration, Dosage, Response or any medication effects. Medication Error Protocol: .... 4. Types of medication errors include: omission ... ... 5. If a medication error has in fact occurred: a. The Director of Nurses and Administrator will be called immediately. b. The physician will be notified of incident for specific orders. These orders will be carried out immediately upon receipt. c. The information will be documented and carried through on their physician order sheet. It will also be noted in the Progress Notes of the Resident(s) involved. d. On any occurrence, an medication incident and accident report will be completed. e. A follow up investigation will be done and plan of correction will be developed as indicated. 6. Immediate care will be taken with the resident and "Focus" charting will include (but, not limited to): a. Vital signs b. Observe entire body c. Access respiratory, cardiac and circulatory systems d. Continue resident observation every shift for 72 hours and document. "B"	S9999		