		(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		7 th Boilebirto.			С			
	6016539		B. WING	B. WING 12/27/20				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 WEST WEBB STREET								
CARMI MANOR REHAB & NRSG CTR CARMI, IL					(EE I			
(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) (COM			
S 000	Initial Comments			S 000				
	Complaint Investigations: 23510635/168042 - 300.660a), 300.661 23510691/168113 - 300.660a), 300.661 23510690/168112- no deficiencies							
S9999	Final Observations			S9999				
	Statement of Licensure Violations: 300.650a) 300.660a) 300.661							
	Section 300.650 Personnel Policies							
	a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the following requirements.							
	Section 300.660 Nursing Assistants							
	a) A facility shall nursing assistant, h services rehabilitati individual who may resident's living quafinancial, or medicathe facility has inquinely Health Care Worke listed on the Health eligible to work for a	on aide, or newly hi have access to a re arters, or a resident' il records, nurse aid ired of the Departm or Registry and the in Care Worker Regis	sychiatric red as an esident, a s personal, le unless ent's ndividual is stry as					
	Section 300.661 H Background Check							
	A facility shall comp Worker Background							

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE (X6) DATE 01/15/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SU		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
				A. BOILDING.			C	
	6016539		B. WING			12/27/2023		
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CARMI MANOR REHAB & NRSG CTR 615 WEST CARMI, IL				「WEBB STF . 62821	REET			
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S9999	Continued From page 1			S9999				
	Care Worker Back	ground Check C	ode.					
	This REQUIREMENT is not met as evidenced by:							
	Based on interview failed to ensure em were completed as no employees were disqualifying offens background check. to affect all 44 residents include:	ployee backgro required and fa working at the es documented This failure has	und checks iled to ensure facility with on their the potential					
	Findings Include:							
	The facility's employee list with handwritten hire dates, dated 12/10/2023 - 12/23/2023 documents V14's (Housekeeping/Laundry) date of hire as 10/23/2022. V14's background checks provided to this surveyor by the facility documents work eligibility: ineligible; V14's background check documents V14 was charged and convicted of statute citation 720 ILCS 5/16-1, Sec. 16-1 (Theft). According to the website Disqualifying Convictions (Illinois.gov) citation 720 ILCS 5/16-1 (Theft) is a disqualifying offense.							
	On 12/27/2023, at stated that she doe was not aware that were ineligible to w (Housekeeping/Lauhousekeeping man (Business Office M background checks that V14 is currently department and ha V1 stated that V14 residents' rooms. On 12/27/2023, at stated that V14.	there were empored. V1 stated the state of t	mployees and ployees who nat V14 I by the old that V17 ns the es. V1 stated laundry he residents.					

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STATE FORM 6899 CB6X11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С		
6016539		B. WING		12/2	7/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CARMIN	MANOR REHAB & NR	SG CTR 615 WEST CARMI, IL	WEBB STR	REET		
(X4) ID PREFIX TAG	ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)		
S9999	Continued From pa	ge 2	S9999			
	Office Manager) stated that she has only been in her current position since September 2021. V17 stated that she does perform background checks on new hires but really has had no training on how to perform them correctly. V17 stated that she was not aware of V14 (Housekeeping/Laundry) or any other employee being ineligible to work. V17 stated that V14 was hired by the previous administrator. V17 stated that V14 would work as a housekeeper when the facility was short-staffed. 2. The facility's employee list with handwritten hire dates, dated 12/10/2023 - 12/23/2023 documents V15's (Nurse Aide) date of hire is 10/23/2023. V15's background checks provided to this surveyor by the facility documents work eligibility: not yet determined. On 12/27/2023, at 11:43 AM, V17 (Business Office Manager) stated that she has only been in her current position since September 2021. V17 stated that she does perform background checks on new hires but really has had no training on how to perform them correctly. V17 stated that V15 (Nurse Aide) was hired on 10/23/2022 and was sent for live scan fingerprinting. V17 stated that she is going to follow-up today to see what the holdup is on why the facility does not have any results back. V17 stated that the results are usually back in a couple of weeks. The facility's matrix roster dated 12/27/23 documents 44 residents currently reside at the facility. The facility's policy and procedure dated 11/5/2019 documents, "Policy Interpretation and Implementation, 4. When conducting background investigations, the facility may consult any or all of					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C 12/27/2023			
6016539			B. WING					
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 615 WEST WEBB STREET CARMI, IL 62821							
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE			
\$9999	the following agence position for which the applied/was hired: a law enforcement agence as a CNA or has accessioned as a CNA or has a C	ies, depending upon the ne applicant/employee a. Local, state, and/or federal gencies; d. State registries of unlicensed individuals ed by a health care employer cress to long-term care ng quarters or financial, al records of long-term care a Healthcare Worker conducted via the state apployee is on the registry, the nem with the facility and check are the employee is eligible to coyee is not on the registry, the nadded to the registry. 8. A. If results have not been received axty (60) day period, the staff noved from the schedule until						

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