	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6009336	B. WING		07/0	1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
CARLIN	/ILLE REHAB & HCC		TH OAK STRI ILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Health Surv	еу				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	ONE OF TWO					
	300.650c) 300.650d) 300.660a) 300.660c)1) 300.661					
	position that require shall contact the Illi and Professional Re individual's license	ersonnel Policies employing any individual in a es a State license, the facility nois Department of Financial egulation to verify that the is active. A copy of the license ne individual's personnel file.				
		ty shall check the status of all Health Care Worker Registry Irsing Assistants				
Illinois Deng	as a nursing assista psychiatric services hired as an individu resident, a resident resident's personal,	shall not employ an individual ant, home health aide, rehabilitation aide, or newly al who may have access to a sliving quarters, or a financial, or medical records, he facility has inquired of the				
		ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 07/23/24

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILDING.			
		IL6009336	B. WING	<u>-</u>	07/0	1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CARLIN	/ILLE REHAB & HCC		TH OAK STR ILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	the individual is liste	th Care Worker Registry and ed on the Health Care Worker to work for a health care				
	nursing assistant or following conditions 1) Is approv Health Care Worke that the nurse aide equivalency require this Part and does in	ity shall ensure that each omplies with one of the s: red on the Department's registry. "Approved" means has met the training or ments of Section 300.663 of not have a disqualifying d check without a waiver.				
	Section 300.661 He Check	ealth Care Worker Background				
	A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.					
	Section 300.661 He Check: State 9999	ealth Care Worker Background				
	Worker Background	oly with the Health Care d Check Act and the health round Check Code.				
	This Requirement is	s NOT MET as evidence by:				
	failed to obtain con- screening, including Registry, the Illinois Inmate search, and checks, to determin criminal history whi	and record review, the facility duct pre-employment g the Illinois Sex Offender Department of Corrections obtain results of fingerprint he if employees had a prior ch would disqualify them for had the potential to affect all				

Illinois Department of Public Health

STATE FORM 6899 7X4W11 If continuation sheet 2 of 10

PRINTED: 08/26/2024 FORM APPROVED

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		IL6009336	B. WING		07/0	1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CARLINI	/II I E DELIAD & LICC	751 NORT	TH OAK STR	EET		
CARLIN	/ILLE REHAB & HCC	CARLINV	ILLE, IL 626	26		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	the 80 residents livi	ng in the facility.				
	Findings include:					
	Policy, revised date This facility prohibits abuse of residents. deprivation by an in of goods or services or maintain physica well-being. This preabuse, even those cause physical harr The facility also proresident property. The subjected to abuse educate all employers annually of the definitions pertaining Annually, the Admir enforcement to revise reporting to law enforcements "Screen knowingly employ in found guilty of abust residents or misapperson at a supervise potential employees criminal background required checks, en (previous and curre confirmation. The faction of the service of the service of the service of against an employer they are unfit for services.	Prevention and Prohibition of 01/24, documents "Policy: s mistreatment, neglect, or This also includes the dividual, including a caretaker, is that are necessary to attain I, mental, and psychosocial sumes that all instances of residents in a coma, can in, pain, or mental anguish. hibits misappropriation of the residents must not be by anyone. The facility will be upon hire and at least initions of the Abuse hibition Policy including g to abuse and neglect. Inistrator will contact local law ew the requirements for corcement." It further ing: The facility will not individuals who have been ing, neglecting, or mistreating propriating their properties. A sory level will interview in acility will make reasonable in acility will make reasonable information about any past ins. The facility will report any actions by a court of law e, which would indicate that rivice as a nurse aide or other nurse aide registry, licensing				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		IL6009336	B. WING		07/0	1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CARLIN	/ILLE REHAB & HCC		TH OAK STR LLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	authorities or other	mandated state agencies."				
	On 06/26/24, ten employee files were reviewed for pre-employment screening. The following was documented:					
	04/29/24. The facil Registry check, an (OIG) search, and a background check not have an Illinois Illinois Department	e's Aide (CNA), was hired on ity initiated a Health Care Office of Inspector General a fingerprint based criminal on 04/24/24. The facility did Sex Offender registry or the of Corrections (DOC) tive search to determine if V11 conviction.				
	facility initiated an C based criminal back and a Health Care I The facility did not I registry or the DOC	was hired on 03/29/21. The DIG search, and a fingerprint kground check on 03/15/21, Registry check on 06/25/24. have an Illinois Sex Offender inmate/wanted fugitive e if V19 had a disqualifying				
	initiated a Health Ca fingerprint based or 10/10/2023, and an facility did not have registry, or the Illino	ed on 10/17/23. The facility are Registry check, a iminal background check on OIG search on 06/25/24. The an Illinois Sex Offender bis DOC inmate/wanted etermine if V20 had a tion.				
	initiated a Health Ca search, and a finge background check not have an Illinois	ed on 8/22/23. The facility are Registry check, an OIG rprint based criminal on 8/16/2023. The facility did Sex Offender registry or the /wanted fugitive search to				

Illinois Department of Public Health

STATE FORM 6899 7X4W11 If continuation sheet 4 of 10

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		IL6009336	B. WING		07/0	01/2024
	PROVIDER OR SUPPLIER VILLE REHAB & HCC	751 NOR	DRESS, CITY, S IH OAK STRI ILLE, IL 6262		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
\$9999	determine if V30 have V31, CNA, was hire initiated a Health Casearch, and a finge background check not have an Illinois Illinois DOC inmate determine if V31 have V32, Dietary Aide, vox facility initiated an Casearch, and a Heology Coryl Casearch, and a Heology Coryl Casearch, and a Heology Coryl Casearch, and an Offingerprint based crossing Coryl Casearch, and an Official typic of the Illinois search to determine conviction. On 06/25/24 at 01:4 Payable/Payroll state Sex Offender, DOC Fugitive, and Illinois employees. She sawhen she checks thanything off and shoor there would be a On 06/27/24 at 10:4 of Operations state.	and a disqualifying conviction. and a disqualifying conviction. and on 8/22/23. The facility are Registry check, an OIG rprint based criminal on 8/16/2023. The facility did Sex Offender registry or the /wanted fugitive search to and a disqualifying conviction. was hired on 02/01/24. The OIG search on 01/24/24, a iminal background check on alth Care Registry check on ty did not have an Illinois Sex the Illinois DOC tive search to determine if V32	S9999			

Illinois Department of Public Health

STATE FORM 6899 7X4W11 If continuation sheet 5 of 10

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6009336	B. WING		07/0	1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CARLIN	/ILLE REHAB & HCC		TH OAK STR ILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	printed out so the A records for any pro	dministrator can review the blems or issues.				
	Medicare and Medi	re Facility Application for caid, CMS 671, dated ts that the facility has 80 ne facility.				
	(C)					
	TWO OF TWO					
	300.1210a) 300.1210b) 300.1210d)1)					
	Section 300.1210 Nursing and Person	General Requirements for nal Care				
	facility, with the parthe resident's guard applicable, must de comprehensive car includes measurab meet the resident's and psychosocial nresident's comprehallow the resident to practicable level of provide for discharg restrictive setting by needs. The assess the active participat resident's guardian applicable. (Section	ticipation of the resident and dian or representative, as evelop and implement a e plan for each resident that le objectives and timetables to medical, nursing, and mental eeds that are identified in the ensive assessment, which attain or maintain the highest independent functioning, and ge planning to the least ased on the resident's care sment shall be developed with tion of the resident and the or representative, as a 3-202.2a of the Act)				
		shall provide the necessary o attain or maintain the highest				

Illinois Department of Public Health

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
741212741	BETTI IO MICHIGALE		A. BUILDING:			
		IL6009336	B. WING		07/0	1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CARLIN	/ILLE REHAB & HCC		TH OAK STR ILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	well-being of the reeach resident's complan. Adequate and care and personal or resident to meet the care needs of the red. d) Pursuant to nursing care shall in following and shall seven-day-a-week. 1) Medications hypodermic, intrave be properly adminise. These requirement by: Based on observation residents (R129) red facility fairnessedents (R129) red fairnessedents (R129) red facility fairnessedents (R129) red fairness	I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident. subsection (a), general acclude, at a minimum, the be practiced on a 24-hour, basis: s, including oral, rectal, enous and intramuscular, shall estered. s were not met as evidenced and to identify, assess, and tions for pain for 1 of 6 eviewed for pain in the sample esulted in R129 moaning in an assessed and treated with	S9999			
		stating, "Oh God, I want to				

Illinois Department of Public Health

STATE FORM 6899 7X4W11 If continuation sheet 7 of 10

AND DIAN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED	
		IL6009336	B. WING		07/	01/2024
NAME OF PROVIDER OR SU	JPPLIER			STATE, ZIP CODE		
CARLINVILLE REHAB	& HCC		TH OAK STR ILLE, IL 626			
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
Assistant (Con her left shave to pool CNA stated V7 exited R speaking will end of hall p do medication pain. On 6/24/24 a level is 10 highest pain been in to color of the level is 10 highest pain been in to color of 6/24/24 R129's room had not been 154/70, hear was 98.4 and R129's room who is still phall. On 6/24/24 and listened "Does it humanywhere?" pressed on stated R129 feel any hard can't remem I've been but V6 stated sh	at 12:15 NA) entide. R12 p, pleas she wood 129's rooth V6, Repair on pass at 12:25 on at 12:27 neck on at 12:30 her lund twhen I R129 sher left I had accompany it company it compa	is PM V7, Certified Nursing tered R129's room to turn her 29 stated, "I'm hurting like I e hurry for the nurse." V7, ald notify R129's nurse now. om. V7 CNA was observed tegistered Nurse (RN) at the medications. V6 continued to after being told R129 was in PM, R129 stated her pain is tale of 1-10 with 10 being stated that her nurse has not	\$9999			

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,	o. oo		A. BUILDING:			
		IL6009336	B. WING		07/0	1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CARLIN	/ILLE REHAB & HCC		TH OAK STR ILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
\$9999	on 6/26/24 at 1:03 It to wait, I know they one, I'm just one of for almost an hour was in pain. R129's Care Plan, or R129's care plan do record/report to nur or requests for pain documents evaluate interventions. Reviedosing schedules a results, impact on from R129's Physician's documented "Pain Pain; 2-3 Mild Pain; Severe Pain; 8-9 Vor Possible Pain." R129's Medication dated June 2024 dotablet 325mg (milligue every 4 hours as no pain scale). R129's was administered 2 R129's MAR does not have a supported that states are supported to the pain medical mild pain. On 7/1/2024 V18, In facility does not have supported that states are supported to the pain medical mild pain.	ge 8 PM, R129 stated "nobody likes are busy and I'm not the only the people," regarding waiting on 6/24/24 after reporting she dated 6/192024 documents beain related to depression. Occuments to monitor, see resident complaints of pain a medication. R129's care plan at the effectiveness of pain and alleviating of symptoms, and resident satisfaction with functional ability and cognition. Orders, PO, dated 6/12/24 Scale: Record q shift: 0-1 Notes, 4-5 Moderate Pain; 6-7 ary Severe Pain; 10 Worst Administration Record (MAR) occuments Acetaminophen grams) give 2 tablets by mouth beded for mild pain (1-4 on MAR documents that R129 at Tylenol 325 mg at 12:44PM. Anot document orders for any action for any pain other than all MDS coordinator stated the area pain policy. V18 stated it aff assess residents for pain medication according to	\$9999			
	(B)					

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PRO

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:	A. BUILDING:		LILD
		IL6009336	B. WING		07/0	1/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CARLIN	VILLE REHAB & HCC		TH OAK STR ILLE, IL 626			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE

Illinois Department of Public Health