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 _____	C 12/18/2024

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

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S 000	Initial Comments Complaint Investigation 24410229/IL182602	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.3210t) 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 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to prevent mental abuse for 1 (R2) of 3 residents reviewed for abuse in the	S9999		

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sample of 3. This failure resulted in R2 being tearful and expressing feelings including being upset and fearful of being kicked out of the facility.

Findings include:

R2's Minimum Data Set (MDS), dated 10/18/2024 documents, she is alert and oriented, cognitively intact.

R2's Undated Face Sheet, documents she was admitted to the facility on 2/22/2023 with a diagnoses major depressive disorder and anxiety.

V1, Administrator's typed stated, dated 12/9/2024 documents this is a statement regarding V6, CNA (Certified Nurse Aide) from 12/8/2024. A resident (R2) came to the ADON's (Assistant Director of Nurse's) office on 12/9/2024 and stated V6 was sleeping in her bed yesterday (12/8/2024.) The ADON came into the administrator's office and investigation was initiated immediately. Based on camera footage, V5 went into (R2's) room on 12/8/2024 at 5:11 AM, she did not leave that room until V7, LPN (Licensed Practical Nurse) went into resident's room at 6:47 AM to wake her up. Administrator, DON (Director of Nurses), ADON and HR (Human Resources) spoke to V7 on phone, and she stated that they were unable to find V6. They entered (R2's) room and found her to be sleeping. V8, LPN stated that V7 asked her to come with her to wake V6 up. Administrator logged into time clock and noted V6 clocked in at 5:11 AM on 12/8/2024.

On 12/17/2024 at 11:03 AM, R2 was resident sitting up in her wheelchair in her room. R2 recalled CNA (V6) coming into her room early on Sunday (12/8/2024) and stated she was cold and

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needed to sleep. R2 stated she always sleeps in her recliner. V6 told R2 not to say a word because if she did, she would be fired and she would get kicked out of the facility. R2 was upset by this and felt it was a serious threat and she didn't want to get kicked out of the facility because she didn't have any place to go. R2 stated staff came into her room about an hour after (V6) had been sleeping and woke her up. She didn't talk to anyone about the CNA sleeping in her bed because she didn't want to get kicked out of the facility then when she spoke to her daughter (V5) on 12/9/2024 she was tearful and told her she's afraid she's going to get kicked out of the facility because a CNA slept in her bed and she was caught by staff but that she didn't tell on the CNA but she was afraid the CNA thinks she told staff she was sleeping in her bed. R2 stated she hopes that (V6) doesn't work at the facility anymore because she's afraid of what she will do to her if she thinks she told on her.

On 12/17/2024 at 11:03 AM V8, Licensed Practical Nurse (LPN) stated she got to work on 12/8/2024 at approximately 5:30 AM and she was told V6 CNA was running late to work that day. At approximately 6:30 AM, V8 hadn't seen V6 and started looking for her. V6 stated she looked in R2's room and observed V6 sleeping in R2's bed. She attempted to wake V6 up, but she told her to get out. V6 then went and reported V6 was sleeping to another nurse V7, LPN. V8 and V7 went to R2's room and V6 woke up and went to work at approximately 6:45 AM. R2 was sitting up in her recliner in her room watching at that time and she wasn't crying or emotionally distressed. V8 stated she didn't report that R2 said not to say anything, or she'd get fired and R2 would get kicked out of the facility. V8 stated she didn't report the incident to management because she

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wasn't assigned to R2 that day.

On 12/17/2024 at 12:23 PM V7, Registered Nurse (RN) she worked on 12/8/2024 day shift and was assigned to R2. V7 stated she knew V6 was running late but didn't know when she arrived to the facility. V6 stated staff couldn't find V6 and V8 reported to her that she found V6 sleeping in R2's bed. V7 and V8 went to R2's room and observed V6 was in fact sleeping in R2's bed. V7 stated she woke V6 up and stated she needed to get to work. V7 didn't report the sleeping incident to management on 12/8/2024. V1 called her on 12/9/2024 and they discussed the incident at that time. R2 wasn't upset on 12/8/2024 when V6 was sleeping in her bed, R2 actually laughed about it and didn't report that R2 told her not to say anything about her sleeping in her bed or she'd get fired and R2 would get kicked out of the facility.

On 12/17/2024 at 12:45 PM V4, Social Services Assistant stated it was reported to her on 12/9/2024 that on 12/8/2024 V6 was found sleeping in R2's bed. V4 and V1 spoke to R2 about the incident on 12/9/2024 and V4 stated the resident got tearful during the interview and stated she didn't want anyone to get in trouble. V4 stated R2 didn't mention fear of being kicked out of the facility and V4 wasn't aware that R2 was fearful of being kicked out of the facility. V4 let R2 know V6 was terminated for sleeping in her bed and R2 understood she was safe at the facility.

On 12/17/2024 at 1:30 PM V5, (family member) stated she went to see R2 in the afternoon on 12/9/2024 and as soon as she walked in the door R2 started to cry and shake and she told her that a CNA slept in her bed the day before and told her if she told anyone she would get fired and R2

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would get kicked out of the facility. V5 stated R2 was very upset and shaking when she told her, and she could tell R2 was scared of the sleeping CNA V6. V5 spoke to the ADON and reported the incident immediately then she showered R2 in an attempt to calm her down. The Administrator spoke to her and R2 after the shower and that's when R2 told the Administrator that the CNA V6 slept in her bed the morning before, and she told her she'd get fired and R2 would be kicked out of the facility if she told on her for sleeping. V5 stated R2 told her that V6 threatened her, and she didn't feel safe at that time.

On 12/17/2024 at 12:33 PM V6, CNA stated she worked at the facility day shift on 12/8/2024 and she had a rough night and that she was really cold and tired. V6 assisted R2 to the bathroom and R2 told her to lay in her bed and rest. V6 stated she thought she'd sit on R2's bed for a few minutes but she fell fast asleep. V7 and V8 woke her up, she didn't know how long she slept for. V6 went straight to work after being woke up and R2 was her usual cheerful self, she wasn't tearful or emotionally upset that day at all. V6 denied telling R2 not to tell staff she slept in her bed because she'd get fired and R2 would get kicked out of the facility. V6 stated she'd worked at the facility for over a year and R2 was like family to her, and she'd never say that to her.

On 12/17/2024 at 10:30 AM, V3 stated she was aware a CNA was found sleeping in R2's on 12/9/2024 when R2's family member R5 reported it to her. An investigation was started immediately. V3 stated when she spoke to R5 on 12/9/2024 she stated R2 told her that if she said anything about R2 sleeping in her bed the CNA would be fired and she would be kicked out of the facility. When V3 spoke to R2 she was very upset

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and tearful stating she didn't want V6 to get in trouble and didn't mention the possibility of being kicked out of the facility.

On 12/17/2024 at 2:11 PM V2 stated on 12/9/2024 sometime after morning meeting the R2, the ADON and V5, R2's family member entered V1, Administrator's office and stated V6 slept in R2's bed the morning before and that R2 didn't say anything because she didn't want to get V6 in trouble. V2 didn't recall who told her that R2 stated that V6 stated to her not to tell anyone that she was asleep in her room because she would get fired and R2 would get kicked out of the facility. R2 was tearful when she entered V1's office to speak to them. R2 has depression and her antidepressant medication was discontinued on 11/18/2024 due to swelling and was restarted due to being tearful and having more signs and symptoms of depression on 12/12/2024.

On 12/17/2024 at 10:35 AM V1 stated R2, V3 and V5 entered her office on 12/9/2024 and R2 was tearful at that time and R2 stated V6 slept in her bed the morning before and that if she told anyone V6 would be fired, and she would be kicked out of the facility. R2 was visibly upset when she told V1 this but R2 had recently had some medication changes so that could have something to do with her being emotional.

The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021 documents residents have the right to be free from abuse, this includes but is not limited to mental abuse.

(B)