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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>145416   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                | (X3) DATE SURVEY COMPLETED<br><br>08/27/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Heartland Nursing & Rehab  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>410 Northwest Third<br>Casey, IL 62420 |  |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |  |   |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few                            | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(continued on next page) |   |  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to protect a resident's right to be free from physical abuse by another resident. This failure affects one resident (R3) out of three reviewed for abuse on a sample list of eight. Findings include: R2's Medical Diagnoses list dated 8/20/25 documents R2 was diagnosed with Autism. Dementia. Anxiety, Insomnia, and Recurrent Depression. R2's Census Details of the same date document R2 had resided at the facility since 10/5/21. R3's Medical Diagnoses List dated 8/20/25 documents R3 was diagnosed with Dementia and Depression. R2's Census detail of the same date documents R3 had resided at the facility since 1/13/22. R2's Minimum Data Set, dated [DATE] documents R2 exhibits verbal behaviors such as screaming, threatening, and cursing, and physical behaviors such as hitting, kicking, pushing, grabbing, and scratching, directed at others which disrupt the living environment. This same Minimum Data Set documents R2 is independent in dressing and walking up to 150 feet. This Minimum Data Set documents R2's behaviors had worsened since the prior assessment dated [DATE]. R2's Minimum Data Set, dated [DATE] documents R2 exhibits physical behaviors directed at others, and other behavior such as hitting or scratching self, pacing, and rummaging, not directed at others. R2's Minimum Data Set, dated [DATE] documents R2 exhibited verbal behavior directed at others. R3's Minimum Data Set, dated [DATE] documents R3 had no exhibited behaviors and required staff supervision or assistance for all aspects of daily care. R2's Nursing Progress Note dated 6/24/25 documents R2 was up all night yelling, screaming, banging on room doors and exit doors, throwing a trash can, wandering in and out of other resident's rooms, and could not be redirected by staff. R2's Nursing Progress Note dated 7/7/25 documents R2 was in the hallway banging on the exit door, screaming dark outside repeatedly, and could not be redirected by staff. R2's Nursing Progress Note dated 8/7/25 documents after an allegation of abuse, (V2 Director of Nursing) watched a video recording of the incident to see R2 kicking another resident (R3) in the right lower leg repeatedly, an incident which prompted staff to send R2 to the emergency room for an evaluation. R3's Nursing Progress Note dated 8/7/25 documents R3 was in the dining room and without provocation, was kicked by R2 causing a small skin tear on R3's right shin. This note documents another resident (R4) had attempted to intervene in the incident which alerted staff to the incident who then intervened. The facility's List of Incidents dated for 6/26/25 through 8/20/25 documents an incident on 8/7/25 with R2 as the initiator of a resident-to-resident physical aggression and R3 being the recipient. The facility's Initial Report to IDPH dated 8/7/25 documents R2 and R3 involved in a resident-to-resident altercation. The facility's final report dated 8/13/25 documents R4 as the sole witness of the incident in the dining room, and video evidence of R2 kicking R3 in the lower leg. On 8/20/25 at 1:50 PM, R4 stated he had witnessed R3 seated in a wheelchair at a table in the dining room minding her own business, then R2 came up and kicked R3 in the leg, then R2 kicked R3 again and was laughing about it. R4 further stated R3 already had sores on her legs and R3's leg started bleeding again when R2 kicked R3. R4 then stated R2 kicked R3 again and he got up and said stop kicking her and that was when staff came and took R2 out of the dining room. R4 continued to state that there was not a lot of staff supervision in the dining room at the time because staff were bringing residents from their rooms to the dining room and then returned back to pick up other residents to bring to the dining room. R4 then stated R2 was back in the dining room the following day (8/8/25) and the staff supervision had not changed. R4 concluded by stating he had witnessed R2 walk up behind a resident (R6) about two and a half or three months ago and smack R6 in the back of the head when R6 wasn't doing anything, but there was no staff around at that time. R4's Minimum Data Set, dated [DATE] documents R4 received a score of 15 out of a possible 15 during a Brief Interview for Mental Status, indicating R4 is cognitively intact. On 8/20/25 at 2 PM, V2, Director of Nursing, stated she had not seen the actual event but did watch the video from the dining room and did see R2 standing by the window, then walk over to R3 who was several tables away and kick R3. V2 stated she had known R2 and her family for about 40 years and thought R3 had some resemblance to R2's mother who R2 used to act violently towards. V2 further stated R2 was on the Autism scale and often acted like whatever she wants, she wants right now, like a small child. V2 stated she had not heard any kind of report about R2 smacking R6 in the head. On 8/20/25 at 2:15 PM, V3, Minimum Data Set Coordinator, stated she had watched the kicking incident between R2 and R3 on the camera. V3 stated she had known R2 and her family for a long time. V3 stated R2 used to be violent with her mother and had talked with R2's sister (V10) who had questioned if R2 was having some regression to an earlier age. V3 stated</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement fall and accident prevention interventions according to a resident's care plan and physician orders. This failure affects one resident (R3) out of three reviewed for falls on the sample list of eight. Findings include: R3's Face Sheet dated 8/20/25 documents R3 had a legally established power of attorney. R3's Medical Diagnoses list of the same date includes Dementia, Major Depression, Hypertension, and Osteoarthritis of the Right Knee. R3's Census Detail of the same date documents R3 was admitted to the facility 1/13/22. R3's Physician order Sheet dated 8/22/25 documents R3 has physician orders to include non-skid strips on the floor in front of her recliner initiated 7/1/24, and to wear (cloth protective leggings) initiated 5/31/25. R3's Minimum Data Set, dated [DATE] documents R3 requires staff supervision and assistance for all aspects of daily living including hygiene, dressing, bathing, transfers, and transitioning between sitting and lying positions, and transitioning from sitting to standing. R3's Care Plan for fall prevention dated from 7/14/24 documents R3 is a fall risk. R3's fall prevention interventions include the area around R3's recliner needs to be kept free of hazards, and (non-slip material) is to be kept in R3's wheelchair seat, both dated as initiated 7/14/24. This care plan includes additional fall prevention interventions including for staff to keep R3's nurse call device in reach, initiated 10/11/24. This same care plan documents R3 is unaware of her safety needs, has Dementia, and often bumps into furniture which results in impaired skin integrity. The staff intervention for this accident problem area was for staff to place (protective leggings) on both of R3's legs for added protection, dated as initiated 5/31/25. There was a second intervention for R3 to have these protective cloth leggings and sleeves on both legs and both arms, dated as initiated 6/2/25. R3's Nursing Progress Note dated 8/20/25 at 8:15 PM documents R3 experienced an unwitnessed fall from bed with multiple bruises, abrasions, and was complaining of right knee pain. A second note on this same date at 8:55 PM documents R3 had swelling of the right knee and above the right eyebrow and was sent to the emergency department for an evaluation. R3's Nursing Progress Notes dated 8/21/25 at 1:09 AM documents facility nursing staff received an update from the emergency department personnel of R3's evaluation results indicating R3 had no fractures, no internal head bleeding, and had surgical glue applied to her right forehead and right knee. A second note on this date at 4:04 AM documented R3's return to the facility and R3 was able to tell nursing staff she had been to the hospital and saw her son but he had to leave because it was getting late, was responding appropriately to questions, told the nurse she had fallen and what injuries she experienced, the nurse noted additional bruising on R3's right elbow in addition to documenting the surgical glue on R3's right eyebrow and right knee. This note further documents R3 stated she was ready to go to bed and might sleep in. On 8/22/25 at 10:20 AM, R3 was seated in her recliner in her own room approximately four feet away from her bed. R3's nurse call light device was hanging from the light fixture on the wall above the left side of R3's bed approximately seven feet away from R3 and on the opposite side of the bed from where R3 was seated. There were no non-skid strips on the floor in front of R3's recliner. R3 was not wearing the protective leggings, nor the cloth protective arm sleeves. On 8/22/25 at 10:35 AM, V3, Minimum Data Set Coordinator, stated she was the nurse on duty and was taking care of R3. V3 stated R3 should have the non-skid material in her wheelchair seat and she personally tries to go around and make sure every resident has the material in their wheelchair seat because the residents will slip out of the wheelchair. V3 observed R3's wheelchair and confirmed the non-slip material was not in the seat. Likewise, V3 affirmed R3's nurse call device was hanging on the light fixture on the opposite side of the bed and was out of R3's reach. V3 stated R3 could hold the call light in her hand but would not realize what the device was to be used for, and R3 might accidentally push the button. V3 noted and confirmed there was not any non-skid strip on the floor in front of R3's recliner and stated that R3 had not attempted to stand up in months. On 8/22/25 at 11:25 AM, V2, Director of Nursing, stated the skin tear observed on R3's right lower leg was not from a resident-to-resident incident from 8/7/25 but rather was from when R3 fell out of bed on 8/20/25. V2 stated R3 often has wounds on both legs due to bumping into things when mobile in her wheelchair because she isn't aware of her own safety needs. V2 confirmed R3's fall on 8/20/25 was unwitnessed. V2 further stated she had personally gone around the facility to check for the non-skid strips for each resident who used them because there had been several residents who changed rooms and R3 was one of those residents. V2 nodded in confirmation that R3 was supposed to be wearing the protective leggings and protective sleeves.</p> |   |  |