STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Caseyville Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 601 West Lincoln Avenue Caseyville, IL 62232	

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on interview and record review, the facility failed to prevent abuse in 2 of 8 residents (R4, R5) reviewed for abuse in the sample of 8. This failure resulted in R5 being scared and not feeling safe in the facility. Findings include: 1. On 2/14/25 at 8:25 AM, R5 stated recently R6 grabbed her by the arm and left bruises as she was walking by him. R5 stated staff didn't intervene right away but did come when she yelled out. R5 stated R6 resides on the same hall as her, she's scared and doesn't feel safe in the facility because of him (R6). R5 stated she wants to be moved off that hallway to get away from R6. R5 stated there haven't been any further incidents with R6 but she doesn't go near him. On 2/14/25 at 12:55 PM, V1, Administrator, stated R5 and R6 either bumped into one another or grabbed ones arm. V1 stated she watched the camera footage and didn't see R6 grab R5's arm, they were just passing one another in the hallway. V1 stated R6 does have behaviors every day, yells/screams out and it gets on the other resident's nerves. V1 stated the other residents may want to hit him, but she hasn't seen R6 hit anyone else. R5's Face Sheet, undated, documents R5 has an admitting diagnosis of Collapsed Vertebrae. R5's MDS (Minimum Data Set) dated 10/21/25, documents R5 has a BIMS (Brief Interview of Mental Status) score of 15, indicating she is cognitively intact. R6's Face Sheet, undated, documents R6 has a diagnosis of Vascular Dementia and Anxiety Disorder. R6's MDS, dated [DATE], documents R6 has a BIMS score of 10, indicating he has moderate cognitive impairment. R6's Progress Note, dated 11/18/24 at 2:03 AM, documents, Aggressive behaviors noted this shift. Resident was cursing at staff, threatening to hit CNA. Resident was easily redirected. At this time resident is in bed resting calmly. Bed in low position, call light in place. No s/s (signs/symptoms) of distress noted, resident denied pain. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R6's Progress Note, dated 12/7/24 at 1:45 AM, documents, Patient has gotten progressive aggressive toward another resident on 200 halls. He continues to go to resident room cursing at him and threating to fight him. Staff took him off the hall x 2 and he was kicking and holding to side rail and didn't want to go and saying, I can go where I want to, and I will when I get ready. He was very nasty and verbally abusive to the staff. After bringing him to this room, he went down again and confronted the resident on 200 halls, holding on to his wheelchair and they both were separated by staff. He then was put in his room. Neither one of the residents were hurt. R6's Progress Note, dated 12/7/24 at 10:10 AM, documents, Patient has been aggressive this morning and yelling, using fouled language, balling up his fist at staff as to hit them, and refused to let staff help him. Patient has been up in wheelchair this tour. R6's Care Plan, dated 4/15/24, documents R6 has a behavior problem, impaired cognitive function and a mood problem. There were not any interventions added after 1/11/24 on R6's care plan to address his aggression with other residents/staff to provide sufficient protection of the other residents from abuse. The Final Report and Conclusion of Incident, dated 1/24/25, documents a comprehensive investigation was initiated and found that on 1/24/25 at approximately 6:15 PM, at the nurse's station R5 told nursing that R6 had grabbed her arm while passing at the nurse's station. It was unwitnessed. Residents were immediately separated. R6 was moved into the hallway. Both residents were assessed with no injuries noted. V5 remains at baseline and shows no signs of mental anguish. The facility finds the allegation of willful abuse unsubstantiated. Both residents plans of care have been updated. 2. On 2/14/25 at 8:30 AM, R4 stated he had an agency CNA (Certified Nurse's Assistant), that came into his room and told him She wasn't f***** cleaning him up, he could clean himself off and to f*** off. R4 stated he had feces on his hand and asked the CNA to clean him and his hand off and she refused. R4 stated he hasn't had that problem before, and other staff came in and took care of him. R4 stated the CNA hasn't been in his room or taking care of him and he doesn't leave his room, so he isn't sure if the CNA works in the facility anymore but someone like her shouldn't be working anywhere with people. R4 stated he was amazed/shocked when it happened, not scared, just shocked, that someone would talk and treat me like that. R4's Face Sheet, undated, documents R4 has a diagnosis of Paraplegia. R4's MDS, dated [DATE], documents R4 has a BIMS score of 15, indicating R4 is cognitively intact and requires substantial/maximal assist with toileting and is dependent with hygiene. The Final Report and Conclusion of Incident, dated 2/10/25, documents a comprehensive investigation was initiated and found that on 2/10/2025 at approximately 8:45 AM, R4 advised a day shift agency CNA (V4) was being very unprofessional with him because he asked her to help get bowel movement off of his hands. R4 stated that the CNA refused to help him. The resident also had an audio recording of the Agency CNA cursing at him and refusing care. Administrator advised nurse to do an assessment. POA (Power of Attorney)/MD (Medical Doctor)/Police were notified. (V4) was DNR'd (Do Not Return) from facility. The Administrator also notified the licensing board about the agency CNA on the allegation of verbal abuse. There were no witnesses and none of the residents on the hall saw or heard anything out of the ordinary. R4 remains at baseline. The facility finds the allegation of willful verbal abuse substantiated. (continued on next page)

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	145585	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caseyville Nursing & Rehab Ctr	601 West Lincoln Avenue Caseyville, IL 62232

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	V1, Administrator stated R4 had an audio recording of V4 cussing at him. V1 reported it to the agency V4 worked for and he was taken off their schedule and placed on the do not return to facility list. V1 stated she also reported the incident to the licensing board. V1 stated the allegation was substantiated. The Abuse Prevention Program policy, dated 6/2008, documents the facility prohibits acts of mistreatment, neglect, abuse and/or crimes from being committed against it's residents. This facility desires to establish a resident sensitive and resident secure environment. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. Prevention of abuse will include resident assessment to ensure person-centered care approaches are individualized and communicated to facility staff.