| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145585 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caseyville Nursing & Rehab Ctr | 601 West Lincoln Avenue<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess 1 (R5) of 3 residents that had a change in condition. This failure resulted in R5 being transferred to the emergency room after not eating or coming out of her room for over 2 days. R5 was admitted to the hospital and diagnosed with RSV (Respiratory Syncytial Virus.)Findings Include:R5's Undated Face Sheet documents she was initially admitted to the facility on [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), pneumonia, nasal congestion and postnasal drip. R5's Minimum Data Set (MDS), dated [DATE] documents she was alert, performed activities of daily living (ADLs) with supervision or touching assistance from staff for eating, toileting, personal hygiene and transfers. Mobility device: wheelchair. Frequently incontinent of bowel and bladder. R5's Physician's Order Sheet (POS) dated 1/2026 and 2/2026 documented the following physician's order dated 7/3/2025 Geri-Tussin MD oral syrup 10-100/MG (milligrams)/5 ML (milliliters) give 10 ml by mouth every 4 hours as needed (PRN) for cough related to cough. A physician's order dated 7/3/2025 Albuterol Sulfate Inhalation Nebulization Solution 1 vial inhale orally via nebulizer every 8 hours PRN for cough/shortness of breath. A physician's order dated 7/3/2025 Benzonatate 100 mg give 1 mg PRN for cough. A physician's order dated 12/14/2025 Guaifenesin ER (extended release) tablet 12-hour 600 mg give 1 tablet every 12 hours PRN for congestion and mucus. A physician's order dated 12/14/2025 Zyrtec allergy oral tablet 10 mg give 1 tablet by mouth every 24 hours PRN for sinus allergies. R5's Medication Administration Record (MAR), dated 1/31/2026 V13, Licensed Practical Nurse LPN documented the following PRN medications were administered: PRN Tylenol 650 mg at 7:00 AM, PRN Benzonatate 100 mg at 7:01 AM, PRN Guaifenesin ER 12-hour 600 mg at 7:01 AM and PRN Zyrtec at 8:38 AM. Staff documented E for effective for all PRN medications administered. R5's Electronic Medical Record, staff documented vital signs dated 1/31/2026 at 7:04 AM 138/81 blood pressure and 82 heartrate, no documentation of R5's temperature, respirations or oxygen saturation status. On 1/31/2026 at 7:57 PM R5's vital signs documented 142/88 blood pressure and 86 heartrates No documentation of R5's temperature, respirations or oxygen saturation status. No assessment of R5's health status was documented on 1/31/2026. R5's Electronic Medical Record, dated 2/1/2026 at 8:50 AM staff documented R5's vital signs 100 temperature, 119/61 blood pressure, 20 respirations, 84 heartrate, 92% oxygen saturation. R5's MAR, dated 2/1/2026 V13, LPN documented PRN medications were administered including Tylenol 650 mg at 9:00 AM, Guaifenesin ER 600 mg at 9:02 AM, Zyrtec 10 mg at 9:02 AM and V19, LPN administered PRN Geri-Tussin 5 ml at 3:39 PM. All PRN medications are documented E for effective on R5's MAR. R5's Nurse's Notes, dated 2/1/2026 no documentation of an assessment of R5 or why the PRN medications were administered. R5's Electronic Medical Record, dated 2/2/2026 at 7:51 AM V13 documented R5's vital signs 99.6 temperature, 152/82 blood pressure, 20 respirations, 76 heartrate, 95% oxygen saturation. R5's MAR, dated 2/2/2026 V13, LPN documented PRN medications were administered: Tylenol 650 mg at 8:03 AM, Guaifenesin ER 600 mg<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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145585 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caseyville Nursing & Rehab Ctr | 601 West Lincoln Avenue<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | at 8:04 AM, Albuterol nebulization at 9:25 AM and Zyrtec 10 mg at 9:02 AM. All PRN medications were documented E for effective. R5's Nurse Progress Notes, dated 2/2/2026 no documentation of an assessment of R5 or why the PRN medications were administered. R5's NP Progress Note, dated 2/2/2025 at 7:00 AM documents chief complaint: Patient seen today for increased fatigue, weakness, diarrhea and alerted mental status. V14 documented R5 was seen today for increasing fatigue, altered mental status and complaints of diarrhea. Patient reports she is not feeling well. on assessment patient not at her baseline self seems very Fatigued with altered mental status. Slow with her response and very uneasy. Patient paler in color glassy eyes noted. Will send patient to emergency room for further evaluation and treatment. Patient looked uncomfortable and did not eat lunch due to poor appetite. Patient reported she has been having loose to stool had malodorous scent could possibly be C. difficile. Pt previously had AKI (Acute Kidney Infection) on CKD (chronic kidney disease) and possibly some fluid depletion. V14 documented R5 skin was parlor and ashen grey skin. V14 documented resident with fatigue and malaise. Very weak and ill appearing today. Keeps saying I don't feel good and foul-smelling stool noted today. Pt reports she had diarrhea all day. Very lethargic and frail. Possible fluid depletion. Not drinking fluids as she needs to. Was slow with response. Not her baseline alert and oriented x 3-4. Pt sent to ER for further evaluation. On 2/6/2026 at 10:00 AM V13, LPN stated she worked day shift on 1/31/2026, 2/1/2026 and 2/2/2026 and was assigned to R5. V13 stated R5 was usually very alert and always out and about being social with other residents and she ate 75-100% of her meals in the main dining room. V13 stated she self-propelled in her wheelchair and she would tell you if you forgot to give her eyedrops and all the things. V13 stated on 1/31/2026, 2/1/2026 and 2/2/2026 R5 wasn't her jolly chipper self. V13 stated R5 stayed in her room all weekend and wasn't eating well. V13 stated she recalled R5 told her she wasn't feeling good and felt crappy. V13 stated she gave R5 several PRN medications for a cough that weekend but R5 continued to stay in her room and wouldn't eat. V13 stated she usually listens to the resident's lungs and takes a full set of vital signs including oxygen saturation when she administers respiratory PRN medication but if it wasn't documented then it wasn't done. V13 stated she didn't notify R5's provider on 1/31/2026 or 2/1/2026 and she didn't know why she hadn't. V13 stated on 2/2/2026 V14 R5's Nurse Practitioner assessed her, and she was transferred to the emergency (ER) shortly after that. On 2/6/2026 at 1:00 PM, V19 LPN stated she worked 2/2/2026 evening shift and was assigned to R5. V19 stated she got report from the day shift nurse V13 that shift and V13 told her R5 wasn't feeling good. V19 stated she couldn't recall if anything occurred abnormal regarding R5 that shift and if there was something abnormal not at R5's baseline she would have documented it in R5's nurse's notes. V19 stated when she administers a PRN medication if for example for a resident that has a cough, she listens to the resident's lung sounds and assesses their vital signs and documents the assessment in the resident's nurse's notes. V19 stated she didn't recall administering a PRN to R5 on 2/1/2026 evening shift but if it's documented then she must have administered it. On 2/6/2026 at 1:01 PM V15, Certified Nurse Assistant (CNA) stated she worked day shift on 1/31/2026 and 2/1/2026 and was assigned to R5. V15 stated this was the first time she was assigned to R5, and she asked other CNAs how R5 is, and they told her R5 is very alert and self-propels in her wheelchair about the facility throughout the day but V15 stated she didn't observe that from R5 that weekend. V15 stated R5 refused to go eat in the dining room and she refused to eat and didn't leave her room all weekend. V15 stated R5 told her she didn't feel good at all, and she informed the nurse (name unknown) that R5 didn't feel good and that she refused to eat meals all weekend. V15 stated she was concerned for R5, so she checked on her often and she was just lying in bed a lot. On 2/6/2026 at 1:15 PM V16, CNA stated she worked the weekend of 1/31/2026 evening<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145585 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caseyville Nursing & Rehab Ctr | 601 West Lincoln Avenue<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | shift and 2/1/2026 evening and night shift and she was assigned to R5 those shifts. V16 stated she worked with R5 often and was familiar with her. V16 stated R5 was usually alert and out of her room. V16 stated R5 usually eats dinner in the dining room, and she usually eats 75% - 100% but on 1/31/2026 and 2/1/2026 R5 refused to come out of her room and refused to eat dinner as well. V16 stated she reported this to the nurse (name unknown) and she was worried about R5 but she couldn't do anything about it because she's not a nurse. On 2/6/2026 at 11:20 AM V17, CNA stated she worked day shift on 2/2/2026 and was assigned to R5. V17 stated R5 is usually alert and up and out of her room self-propelling in her wheelchair. V17 stated R5 complained of feeling nauseous that morning and she refused breakfast. V17 stated R5 usually lays in bed in the morning but she continued to lay in bed after 10:00 AM and she checked on R5 and she had vomited all over her blanket and clothes and she assisted to get her cleaned up. V17 stated R5 was continent of bowel and bladder but this day she was incontinent. V17 stated she didn't receive report from the night shift nurse or CNA, so she didn't know how R5 was over the weekend. V17 stated she didn't take R5's vital signs that shift because V13, LPN didn't ask her to. V17 stated she reported everything to V13 that R5 refused breakfast and how she complained she felt nauseous, when she vomited, that R5 was incontinent of bowel and bladder and that she wasn't herself throughout that morning. On 2/6/2026 at 4:23 PM V18, LPN stated he was walking down the hall on 2/2/2026 and V17, CNA stopped him and stated R5 didn't look good and wasn't herself. V18 stated he went to R5's room immediately and noted she didn't look like herself she looked drained, and her face was an ashy color. V18 stated he reported his concerns to R5's nurse, V13 who was at the nurse's station at that time and V14, NP was standing there and heard the concerns. V14 grabbed her stethoscope and went to assess R5 immediately and R5 was transferred to the emergency room right after that. R5's Hospital After Visit Summary, dated 2/5/2026 documents diagnosis: RSV. R5 was administered an antibiotic, Cefdinir, prednisone and had blood cultures drawn. On 2/6/2026 at 2:52 PM V2, Director of Nurses (DON) stated when a resident has a diagnosis of COPD and is exhibiting respiratory symptoms, she expects the nurse to take a full set of the resident's vital signs including oxygen saturation and to assess the resident's lung sounds to ensure the resident doesn't have abnormal vitals and/or lung sounds and to document the assessment in the resident's electronic medical record. V2 stated that when a resident that is usually very sociable refuses to leave their room for one meal, she expects the nurse to go assess the resident and do a head-to-toe assessment because the resident not wanting to come out of their room warrants a further assessment. V2 stated [NAME] a resident that eats well refuses two meals V2 stated she expects the nurse to notify the provider and find out why the resident isn't eating. V2 stated when a resident refuses to eat and doesn't leave their room it's a clear change in condition and the nurse should have notified the provider when R5 refused to eat breakfast over the weekend of 1/31/2026 and should have reported to the provider that R5 stated she didn't feel good as well. On 2/6/2026 at 2:15 PM V14, R5's NP (Nurse Practitioner) stated R5 is very alert and always out of bed and on the move and if R5 is lying in bed that means she doesn't feel good. V14 stated R5 is pleasant and has a good appetite. V14 stated she is available when staff have resident related concerns, they call her all the time, but no staff reported that R5 had health concerns or a change in condition on 1/31/2026 through 2/1/2026. V14 stated R5 has COPD and when she has respiratory symptoms, she expects the nurse to take a full set of vital signs including her oxygen saturation and to assess R5's lungs then to document the assessment in R5's electronic medical record and then to notify her of R5's respiratory status. V14 stated this assessment is to ensure R5 is at baseline and to see if she needs to order additional medication or a chest x-ray or transfer R5 to the ER for further evaluation and treatment. V14 stated she didn't know R5 wasn't<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145585 | A. Building<br>B. Wing | 02/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Caseyville Nursing & Rehab Ctr | 601 West Lincoln Avenue<br>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 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | feeling good, that she refused all meals on 1/31/2026, 2/1/2026 and breakfast on 2/2/2026 and didn't know that staff had administered PRN medications for respiratory symptoms or had vomited until V18, LPN came to the desk and told V13, LPN that R5 didn't look good and he was concerned. V14 stated she grabbed her stethoscope and went to assess R5 immediately at that time (time unknown) and stated R5 didn't look good at all, her color was ashy. R5 told her that she felt weak and had multiple episodes of diarrhea which smelled like C-Diff and she was concerned for R5 so she transferred her to the local ER. V14 stated the hospital called the facility and reported R5 was diagnosed with RSV at the hospital and was admitted to the hospital for a few days. V14 stated she doesn't know what time she assessed R5 that day, but it was in the afternoon, and staff transferred R5 to the ER shortly after she assessed her. The Facility's Notification Changes in Condition, revised 12/2024 documents, it is the responsibility of the licensed staff to contact the physician whenever there is a change in the resident's physical status. Acute change in condition is a sudden, clinically important deviation from a patient's baseline in physical or functional status that without intervention, may result in complications or death. Policy guidelines and interpretation: upon identification of any change in condition licensed nursing personnel will contact the residents attending physician/on-call physician/practitioner to notify him/her of the change. Acute changes in condition should occur immediately upon recognition. All notifications should be preceded by an appropriate physical assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions. All changes of condition require follow-up assessment and documentation of resident condition which should include, at a minimum: vital signs, pain, orientation and any change from baseline status. |