

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  05/31/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35156</p> <p>Based on interview and record review, the facility failed to ensure call lights were being answered in a timely manner for 5 of 7 residents (R32, R36, R70, R77, R82) reviewed for call lights in the sample of 54.</p> <p>Findings include:</p> <p>On 5/28/2024 at 8:45 AM, V7, Activity Director, was asked to bring 4-5 residents to a group meeting that were able to answer questions and were interviewable. The following residents were brought to the meeting; R32, R36, R70, R77 and R82.</p> <p>During the group meeting on 5/29/2024 at 8:45 AM, R32, R36, R70, R77 and R82 all stated they were having issues with the call lights not being answered in a timely manner on all shifts. They stated the average wait time is probably 30 minutes with some times even longer depending on what is going in in the facility.</p> <p>R32's Minimum Data Set (MDS), dated [DATE], documented that R32 was cognitively intact for decision making of activities of daily living.</p> <p>On 5/29/2024 at 8:52 AM, R32 stated, We have been having issues with call lights and we have talked about it at the resident council meeting. It does not seem to be getting better. It depends on the day and what else is going on but for those of us that need help we have to wait and call light has been a big problem here.</p> <p>R70's MDS, dated [DATE], documented, R70 was moderately impaired for cognition for decision making of activities of daily living.</p> <p>On 5/29/2024 at 8:54 AM, R70 stated, I am in a wheelchair, and I do not even use the call light because why bother when they never answer it. Thankfully, I just yell for help or go and find someone when I need help.</p> <p>R72's MDS dated [DATE], documented R72 was cognitively intact for decision making for activities of daily living.</p> <p>(continued on next page)</p>

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/29/2024 at 8:56 AM, R72 stated, I am getting ready to leave soon. I have been in a wheelchair, and I need help. The call lights are a big problem because staff are not answering them or worse, yet they come in and answer the call light then turn off the light and never come back.</p> <p>R82's Minimum Data Set (MDS), dated [DATE], documented R82 was moderately impaired for decision making of activities of daily living.</p> <p>On 5/29/2024 at 8:59 AM, R82 stated, I can do most things by myself, but everyone has been complaining (that needs help) about the call lights taking a long time to answer.</p> <p>R77's MDS, dated [DATE], documented, R77 was cognitively intact for decision making for activities of daily living.</p> <p>On 5/29/2024 at 9:00 AM, R77 stated, I am fortunate that I can do most things by myself. I have been coming to these meetings for about four months and residents have been complaining about call lights not being answered. Residents needing help and residents not getting help.</p> <p>R36's MDS, dated [DATE], documented that she was cognitively intact for decision making of activities of daily living.</p> <p>On 5/29/2024 at 9:01 AM, R36 stated, Call lights are a problem and we have told (V1) and the ombudsman but they are still not answered in a timely manner.</p> <p>Resident Council Meeting Minutes, dated 5/20/204, documented, Call lights need answered ASAP.</p> <p>Resident Council Meeting Minutes, dated 2/26/2024, documented, Long call light time.</p> <p>Resident Council Meeting Minutes, dated 3/26/2024, documented, Call lights take time to be answered.</p> <p>R190's Grievance, dated 2/27/2023, documented, No one answer call lights. Do not work together. Findings of investigation: Ongoing issues, Put in place call light audit. Plan to resolve Complaint: Call light audit, in-services. Grievance was not resolved.</p> <p>Resident Council Meeting Minutes, dated 4/25/2023, documented, Call lights not being answered timely or coming in and saying, I'll be back then not returning.</p> <p>On 5/29/2024 at 10:02 AM, V6, Ombudsman, stated, I have been having a lot of complaints from residents and family members regarding call lights for the past three months. I have approached (V1, Administrator) and she tells me she is going to address it, but it is still happening and nothing has changed.</p> <p>On 5/29/2024 at 3:02 PM, V1, Administrator stated, We have had in-services on call lights. I have been told there are some issues with call lights. I am not sure when the last audit was done or what the results were from that audit.</p> <p>On 5/29/2024 at 4:02 PM, V1 stated, There was no policy on call lights.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Resident Right Policy with a revision date of 11/18, documented, Nursing home residents have the right to: Dignity, respect and a comfortable living environment.</p> <p>The Resident Right Policy with a revision date of 11/18, documented, Nursing home residents have the right to: Dignity, respect and a comfortable living environment.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35156</p> <p>Based on observation, interview and record review, the facility failed to ensure resident clothes were being maintained, cleaned, and returned in a timely manner for 5 out of 7 residents (R32, R36, R70, R77, R82) reviewed for laundry in the sample of 42.</p> <p>Findings include:</p> <p>On 5/28/2024 at 8:45 AM, V7, Activity Director, was asked to bring 4-5 residents to a group meeting that were able to answer questions and were interviewable. The following residents were brought to the meeting R32, R36, R70, R77 and R82.</p> <p>During the group meeting on 5/29/2024 at 8:45 AM, R32, R36, R70, R77 and R82 all stated they were having issues with missing laundry and the facility was not doing anything about it.</p> <p>1.R36's Minimum Data Set (MDS), dated [DATE], documented that she was cognitively intact for decision making of activities of daily living.</p> <p>On 5/29/2024 at 9:01 AM, R36 stated, We have issues with laundry too and things go missing and they never find it or replace it. It's not right!</p> <p>2.R72's MDS, dated [DATE], documented that R72 was cognitively intact for decision making for activities of daily living.</p> <p>On 5/29/2024 at 8:56 AM, R72 stated, I have had lots of missing clothing lost and never returned and not replaced.</p> <p>3. R82's Minimum Data Set (MDS), dated [DATE], documented that R82 was moderately impaired for decision making of activities of daily living.</p> <p>On 5/29/2024 at 8:59 AM, R82 stated, Clothes are always going missing and staff do not really help you or really care. I have lost lots of clothes, told them about it and they were never replaced.</p> <p>4. R77's MDS dated [DATE] documented, R77 was cognitively intact for decision making for activities of daily living.</p> <p>On 5/29/2024 at 8:52 AM, R77 stated, We have some issues with clothes going missing and the facility not even trying to find them or replace them. This has been going on for months now. They lose your clothes and don't care or even try to find you something different. I went inside the laundry room because they told me any clothing without labels is put in a bin for residents to go through. When I asked, I was told the bin was empty because they had donated the clothes. That does not make sense to me. Why would you donate our clothes? How does that make sense nobody told me there was a bin of unidentified clothes I could go through.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5- R32's Minimum Data Set (MDS), dated [DATE], documented that R32 was cognitively intact for decision making of activities of daily living.</p> <p>On 5/29/2024 at 8:52 AM, R32 stated, They don't care about our clothes. They lose our clothes and don't find them or replace them.</p> <p>R58's Resident Family Grievance, dated 12/27/2023, documented, Resident stated that CNA's take her clothes out of her room for laundry but not returning them. She's missing about 10 pair of slacks shirts and socks.</p> <p>R60's Resident Family Grievance, dated 3/6/2024, documented, Rude answer about my clothing. Plan to resolve: This writer spoke to housekeeping/laundry supervisor in regards to clothes. Supervisor will get with (R60) resident was advised to have name marked in clothing so laundry will know they belong to him. I am missing tons of shirts and pants.</p> <p>R62's Resident / Family Grievances, dated 1/5/2024, documented, Resident's father stated that resident's blue sweat suit that he received as a gift for Christmas is missing, it's a pullover hoodie no zipper with pants to match. Resident's father wants a replacement. Findings of investigation, Resident clothes were not found. POA (Power of Attorney) did not want to go to laundry to identify belongings. Plan to Resolve: Have resident's POA identify clothing in laundry.</p> <p>On 5/29/2024 at 10:08 AM, V6, Ombudsman, stated, I have been having a lot of complaints from residents and family members regarding laundry being lost and never found or replaced. I talked with (V1) about for several months, but it does not seem to improve or get better.</p> <p>V18, Laundry Supervisor, stated that residents sign a contract when they come in the facility that their clothing is to be marked with their name on it and clothing will be thrown away if not claimed after 60 days. We contact the POA (Power of Attorney) or family representative and tell them to come in and go through the lost and found clothing before the items are thrown away. We only have so much room for storage.</p> <p>On 5/31/2024 at 10:10 AM, A review of admission contract was reviewed, and it does not document that clothing with no name will be discarded after 60 days.</p> <p>On 5/31/2024 at 10:36 AM, in the laundry room with the wheelchairs was a rack with 5 large boxes approximately 24 inches by 18 inches by 24 inches each box contained resident clothing that was not labeled. (e.g., shirts, pants, pajamas).</p> <p>On 5/31/2024 at 10:39 PM, V18, Laundry Supervisor, stated, These 5 boxes have clothes that do not have labels or names.</p> <p>The Resident Right Policy with a revision date of 11/18, documented, Nursing home residents have the right to: Dignity, respect and a comfortable living environment.</p> <p>The Notification of Policy Regarding Personal Property, undated, documented, This facility understands the value and importance of everyone's personal property. Because we care, we make every effort to assure that your possessions are not lost, misplaced or stolen.</p>		

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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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35156</p> <p>Based on interview and record review the facility failed to ensure abuse did not occur for 4 of 5 residents (R40, R49, R74, R75) reviewed for abuse in the sample of 42.</p> <p>Findings include:</p> <p>1. R49's Physician Order Sheet for May 2024, documented a diagnosis of anxiety disorder, dementia in other diseases classified elsewhere, moderate with agitation, alcohol abuse with other alcohol induced disorder, alcoholic hepatitis without ascites, cocaine abuse with cocaine induced disorder.</p> <p>R49's Minimum Data Set (MDS), dated [DATE], documented R49 was severely impaired for cognition of activities of daily living. Partial/moderate assist for most activities of daily living and he is in a wheelchair.</p> <p>R49's Care Plan, undated, documented, (R49) has impaired cognitive function related to his Dementia. R49's Care Plan does not address abuse.</p> <p>R49's Progress Notes, dated 3/3/2024 at 9:03 PM, documented, Note Text: 10:00 PM resident involved in resident to resident altercation. This resident observed standing over another resident punching resident near head. Multiple staff approached and separated residents, no acquired injuries, resident sister made aware of altercation, ADON (Assistant Director of Nursing) made aware via phone call, MD (Medical Director) made aware.</p> <p>R49's Final Report, dated 3/7/2024, documented, On 3/3/2024 (R68) resident was seen getting up out of wheelchair, and made contact with another resident (R74). This occurred at the nurse's station by hall D at around 10:30 PM. This was a witnessed situation. Neither resident is an identified offender. Family and physician notified. Local police also notified. Residents were immediately separated. Nurses and CNAS were at the nurse station at the time but could not get to (R68) quick enough. No injury noted. During this investigation and the use of cameras that are on site shows (R68) did get out of his wheelchair, stood up and made contact with (R74) on his head with right fist. (R68) is on 15 minute checks. Both residents redirected to other activities. Facility encourage staff to keep them apart, if possible, with other activities.</p> <p>2. R75's MDS, dated [DATE], documented R75 was moderately impaired for cognition for activities of daily living.</p> <p>R75's Care Plan, undated, documented, (R75) has a behavior problem. Diagnosis of anxiety and cognitive communication deficit. (R75) has potential to be verbally aggressive and scream at others r/t Ineffective coping skills &amp; cognitive communication deficit.</p> <p>(continued on next page)</p>		

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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>R75's Progress Notes, dated 3/3/2024 at 10:27 PM, documented, Note Text: resident was sitting at nursing station sitting area when another resident physically attacked him, given blows to the head. No injury noted. Resident stated, I'm tired of this mother fuc*er talking sh*t I'm go hit again. Resident was separated move to different areas DON (Director of Nursing, MD (Medical Director) POA (Power of Attorney) notified. No injury noted. Resident is sitting in wheelchair with no complaints.</p> <p>On 5/29/2024 at 10:50 AM, V5, Licensed Practical Nurse (LPN), stated, I remember (R49) started the resident-to-resident altercation back in March. (R49) hit (R75). Both residents are aggressive and both residents are confused. I remember I intervened immediately, and no resident was hurt and/or had any injury from the altercation.</p> <p>On 5/29/2024 at 8:41 AM, V1, Administrator, stated, I reviewed the cameras and (R49) got out of his wheelchair back in March and hit (R75) on the head with his right fist. Neither resident was hurt.</p> <p>On 5/29/2024 at 10:22 AM, V2, Director of Nursing (DON), stated, I believe the altercation with (R49) and (R74) occurred in the evening back in March. They are both very confused. At one time they were roommates. They both have a history of hitting staff.</p> <p>On 5/29/2024 at 1:32 PM, V3, Assistant Director of Nursing, stated, I vaguely remember the incident. I know both (R49) and (R74) both have a history of combative behaviors and had an altercation. (R49) gets in and out of his wheelchair and I believe (R49) hit (R74), but neither resident was injured. At one time they were roommates.</p> <p>3. R36's MDS, dated [DATE], documented that R36 was cognitively intact for decision making of activities of daily living.</p> <p>05/28/24 at 1:36 PM, R6 stated, I was involved in a fight with (R40) because she was going through stuff in my room, I don't like her going through my stuff or my roommate's stuff. It's not right.</p> <p>R36's Progress Note, dated 5/26/2024 at 9:44 AM, documented, Note Text: writer made aware approximately 9:08 AM, resident made physical contact with (R40) CNA states that (R36) said (R40) was going through roommates belongings and attempted to redirect (R40) &amp; licks were exchanged; resident separated; [NAME] on call and made aware at 0922; [NAME] administrator called approximately 9:32 AM and instructed to have CNA (witness) to write a statement and place it under her door; resident daughter &amp; POA (power of attorney), made aware; POA asked if she had any bruises; writer informed no injuries/bruising noted; states that (R36) had informed her that someone had been coming into her room and touching her things; writer informed POA that we have dementia patients that wander and go into other resident room, however physical contact is not appropriate as mean of redirection; understanding voiced; states she will be to visit resident later; no further needs voiced; will monitor.</p> <p>4. R40's MDS, dated [DATE], documented that R40 had memory problems and was severely impaired for cognition for activities of daily living.</p> <p>R40's Care Plan, undated, documented, (R40) is an elopement risk/wanderer related to diagnosis of Alzheimer, confusion.</p> <p>On 5/28/2024 at 9:01 AM, V30, Licensed Practical Nurse, stated, (R40) is very confused and she has a habit of wandering around the facility and has a habit of wandering into resident's room.</p> <p>(continued on next page)</p>		

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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>R40's Progress Notes, dated 5/27/2024 at 5:55 PM, documented, Note Text: observation r/t (related) resident to resident altercation, resident denies pain rom (Range of Motion) wnl (within normal limits), no s/s (signs and symptoms) of distress, up in wc (wheelchair) propelling self about facility.</p> <p>On 5/31/2024 at 9:46 AM, V1, Administrator, stated, I did an initial and will have the final report finished today. It looks like (R40) entered (R37's) room and (R37) became upset and started hitting her.</p> <p>The Abuse Prevention Program Policy with a revision date of March 2018, documented, The facility affirms the right of our residents to be free from abuse (verbal, mental, sexual, or physical, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and physical and chemical restraints that are not required to treat a resident's medial symptoms. This facility therefore prohibits acts of mistreatment, neglect, abuse and/or crimes from being committed against its residents. This facility desires to establish a resident sensitive and resident secure environment. Physical abuse including hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>35156</p> <p>Based on interview and record review, the facility failed to adequately develop an ongoing infection control program that adequately collected data to calculate and analyze infection rates and failed to operationalize infection control policies to adequately define infection control practice in the facility. This has the potential to affect all 88 residents living in the facility.</p> <p>Findings Include:</p> <p>The facility Infection Control Log was requested for the entire year since the last survey.</p> <p>On 5/28/2024 at 9:02 AM, An infection control log was provided but did not have any dates or organisms listed or documented.</p> <p>On 5/28/2024 at 10:43 AM, V3, Assistant Director of Nursing (DON) stated, I just recently was hired and took over as the infection control preventionist in March. I have completed this course and got my certificate. All of the surveillance, everything should be in the book. I am new to this position, and I just have not gotten the surveillance/infection control where it needs to be at. I know there are no organism listed.</p> <p>The infection control book provided by V3 on 5/28/2024 listed residents' names and identified urinary tract infections along with the medication but none of the urinary tract infections had organisms documented and no organisms were provided for the entire book. The book was incomplete.</p> <p>The Long -Term Care Facility Application for Medicare and Medicaid form, dated 5/28/2024, had a census of 87 residents.</p> <p>The Facility Infection Control Program Policy revision date or 8/2017 documented, The facility will maintain an infection control program that is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. The ICP (Infection Control Preventionist) will investigate, control and prevent the infections in the facility by monitoring laboratory reports and physician orders and following symptomatic trends within the facility that may indicate patters of infection.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>35156</p> <p>Based on interview and record review the facility failed to ensure the residents were given the correct antibiotics for the organism causing infection for 2 of 4 residents (R40, and R74, ) viewed for antibiotic stewardship in the sample of 42.</p> <p>Findings include:</p> <p>1. R40 was documented on the April 2024 Infection Control Log for a urinary tract infection. The log documented, Cephalexin Oral Tablets 500 milligrams give 500 mg (milligrams) by mouth two times a day for UTI (urinary tract infection) for 10 days.</p> <p>R40's Progress Notes, dated 4/16/2024 at 11:51 AM, documented, ABT (antibiotic) ordered and awaiting delivery for UTI (urinary tract infection).</p> <p>R40's Physician Order Sheet (POS) for April 2024, documented, Cephalexin Oral tablet 500 MG (milligrams) (cephalexin) give 500 mg by mouth two times a day for UTI for 10 days. Order date 4/17/2024, end date 4/27/2024.</p> <p>R40's Medication Administration Record (MAR), dated 4/1/2024 to 4/30/2024 documented, Cephalexin oral tablet 500 MG (cephalexin) give 500 mg by mouth two times a day for UTI for 10 days. Start date 4/17/2024.</p> <p>On 5/29/2024 at 10:00 AM, a Culture and Sensitivity Report (C&amp;S) was requested for R40, and no C&amp;S was provided for R40 to ensure Cephalexin Oral Tablets 500 milligrams was the correct medication for the urinary tract infection for April 2024.</p> <p>2. R74 was documented on the Infection Control Log for May 2024 for a urinary tract infection. The log documented, Levofloxacin Oral Tablet 750 mg give 1 tablet by mouth one time a day related to urinary tract infection site not specified.</p> <p>R74's Progress Note, dated 5/19/2024 at 10:27 PM, Note Text: Due to (R74's) agitation and aggressiveness today and yesterday. (Doctor) gave new orders to recheck him for UTI.</p> <p>R74's POS, dated May 2024, documented, UA (urinary analysis), C&amp;S one time only related to urinary tract infection. Start date 5/21/2024. Cefepime HCL Intravenous Solution 2 GM (Grams)/100ML (milliliters) (Cefepime HCL) use 2 grams intravenously every 12 hours for infection related to urinary tract infection for five days. Start date 5/13/2024, end date 5/19/2024. Cefepime HCL intravenous solution 2 GM/100 ML (Cefepime HCL) use 2 grams intravenously two times day for infection related to urinary tract infection. Start date 5/13/2024 end date 5/16/2024. Cefepime HCL intravenous solution 2 GM/100ML (Cefepime HCL) Use 2 gram intravenously two times a day for infection related to urinary tract infection for 2 days. Start date 5/13/2024 end date 5/15/2024.</p> <p>R74's MAR for May 2024, documented, Levofloxacin oral tablet 750 MG (levofloxacin) give 1 tablet by mouth one time a day related to urinary tract infection, start date 5/13/2024, d/c date 5/13/2024. It also documented that one dose was given on 5/13/2024.</p> <p>(continued on next page)</p>		

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  05/31/2024
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)
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/29/2024 at 10:02 AM, a Culture and Sensitivity Report (C&amp;S) was requested for R74, and no C&amp;S was provided for R74 for May 2024.</p> <p>On 5/31/2024 at 10:12 AM, V3, Infection Control Preventionist/Assistant Director of Nursing stated, I just recently was hired and took over as the infection control preventionist back in March. I have completed this course and got my certificate. All the surveillance, everything should be in the book. I am new to this position, and I just have not gotten the surveillance/infection control where it needs to be at. I know there are no organism listed and I do not always get the Culture and Sensitivity back when residents go out to the hospital.</p> <p>The Antibiotic Stewardship Program with an effective date of 2017, documented, Antibiotic Stewardship refers to the appropriate use of antibiotics when they are actually needed and using the right antibiotic for the right infection. Antibiotic resistant occurs when bacteria adapt so that the drugs used to treat infection as less effective or do not work at all. Overexposures to antibiotics creates drug-resistance strains of bacteria and healthcare-associated infections. When this occurs, it is difficult to treat infections residents may develop complications leading to hospitalization and mortality. Cultures will be obtained to ensure appropriate diagnosis when possible. The facility's IP (Infection Preventionist) will monitor results of cultures routinely to ensure MDROs (multi drug resistance organisms) are addressed appropriately.</p>