STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146117	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casey Healthcare Center	100 N.E. 15th 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35380 Based on interview and record review, the facility failed to protect the resident's right to be free of physical abuse by another resident for three of three residents (R1, R7, R8) reviewed for physical abuse on the sample list of 12. Findings include: The facility's Incident Report Form - Illinois Department of Public Health (IDPH) Notification dated 2/23/24, documents R8 was in the dining room when R8 reached out and made contact with R7's forehead. R7 and R8 were separated and assessed. R8's undated Face Sheet documents R8's diagnoses as: Unspecified Dementia, Unspecified Severity, with Psychotic Disturbance, Depression Unspecified, and Unspecified symptoms and signs involving Cognitive Functions and Awareness. R8's Minimum Data Set (MDS) dated [DATE], documents R8 is not cognitively intact. R8's Care Plan dated 2/27/24, documents R8 is known/has a history of displaying inappropriate behavior and has a history of hitting staff. R8's untitled document dated 1/4/24, documents R8 having behaviors which include physical aggression-push, grab, physical abusive-hit, scratch, and does not respect personal space. The facility's IDPH Notification Form dated 5/6/24, documents R1 made contact with R7's face. R1 and R7 immediately separated and assessed. R1's undated Face Sheet documents R1's diagnoses as: Mild Neurocognitive Disorder due to known Physiological condition with behaviors and Unspecified Dementia, Unspecified severity with Agitation. R1's MDS dated [DATE], documents R1 is not cognitively intact. R1's Psychosocial assessment dated [DATE], documents R1 enters bedrooms uninvited, rummages in other's space, and is socially inappropriate. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Care Plan dated 4/25/24, documents R1 is/has the potential to be physically aggressive, pinches, bites, and kicks. On 5/23/24 at 1:05 PM, R8 stated she never hit anyone on the forehead or any where else. R8 stated R8 does not think she knows R7 and she doesn't remember hitting anyone. R8 stated R8 might have bumped into someone accidentally but has never hit anyone her whole life. On 5/23/24 at 1:15 PM, R1 was asked about the incident with R7. R1 is not able to stop walking, look at someone's face, understand or communicate. On 5/24/24 at 10:00 AM, R7 stated R1 kept coming in R7's room and R7 asked R1 to please leave and R1 just looked at R7. R7 stated R7 told R1 that R1 is not supposed to be in R7's room. R7 stated R1 kept banging on R7's closet door and R7 had a big shirt on and R1 hit the shirt and R7's face. On 5/24/24 at 10:10 AM, R7 stated R7 went to sit at her (R7) table in the dining room and R8 sat down and R8 asked if R7 wanted a cup of coffee and R7 stated it's right over there and R7 pointed to where the coffee was. R7 stated R8 got up and flicked the side of my (R7) head and moved to a different table. On 5/14/24 at 3:32 PM, V6 Licensed Practical Nurse (LPN) stated R1 can have aggressive behaviors at times. On 5/24/24 at 11:00 AM, V18 LPN stated R1 sometimes has physically aggressive behaviors. On 5/23/24 at 12:15 PM, V1 Administrator confirmed R1 made contact with R7's face and confirmed R8 made contact with R7's forehead. The facility's Abuse Prevention Program Policy dated Revised 11/28/2016, documents this facility is committed to protecting our residents from abuse by anyone including other residents. This policy also documents this facility desires to prevent abuse by establishing a resident sensitive and resident secure environment. This policy also documents as part of the resident social history assessment, staff will identify residents with increased vulnerability for abuse or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches, which would reduce the chances of mistreatment, neglect, and abuse of these residents.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on interview and record review, the facility failed to follow physician orders to obtain a repeat Esophagogastroduodenoscopy (EGD) for one resident (R2) and failed to collect a urinalysis for one resident (R1). R1 and R2 are two of three residents reviewed for following physician orders in the sample list of 12. Findings include: 1.) R1's undated Cumulative Diagnosis Log documents R1's diagnoses as: Agitation due to Dementia, Major Neuro Cognitive Disorder, and Alzheimer's Disease probable with Behavioral Disturbances. R1's Minimum Data Set (MDS) dated [DATE], documents R1 is always incontinent of urine and requires assist with toileting. On 5/14/24 at 3:45 PM, V6 Licensed Practical Nurse (LPN) confirmed, labs (laboratory blood work) and a urinalysis (UA) were ordered for R1 on 4/28/24 at 6:20 PM. V6 stated the telephone order and blood draw information are put on the laboratory sheet and then night or day shift staff obtain the specimens. V6 stated she passed the information on to V7 LPN (night shift) who drew the blood for the laboratory. V6 stated V6 did not obtain the UA for R1 because R1 did not want to sit down all evening. V6 stated the order to get a UA should not have gone through so many nurses before it was obtained. On 5/14/24 at 2:46 PM, V2 Director Of Nursing (DON) stated the urine should have been obtained as soon as possible after the order was given since the order was given after the second fall on 4/28/24. V2 confirmed the order for a urinalysis was given on 4/28/24 and obtained on 5/2/24. 2.) R2's undated Cumulative Diagnosis Log documents R2's diagnoses as: Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cardio Vascular Accident, Coronary Artery Disease, Peripheral Artery Disease, History of Pulmonary Embolism, Chronic Kidney Disease Stage III. R2's Physician Order Sheet (POS) dated 5-1-24 - 5-31-24, documents R2's diet order as mechanical soft, thin liquids, swallow precautions, supervision at meals, anti-reflux precautions, small meals, small bites at meals and limit acidic food. This same POS documents Oxygen 2-4 liters to maintain oxygen saturation above 90%. R2's Situation, Background, Assessment, and Recommendation (SBAR) form dated 1/28/24, documents food/foreign substance stuck in R2's throat with increased aspiration risk, request to be sent to the emergency department (ED) for removal. R2's Final Report for 1/28/24, ED visit documents EGD completed with findings of food impaction from the oropharynx to the lower third of the esophagus removed using suction, rescue net and rat-tooth forceps - at the completion of the exam, the esophagus was free of any residual foreign body or debris - recommend minced or soft to chew diet for the next month as patient remains high risk for repeat obstruction - refer for repeat EGD in 4 weeks to perform esophageal dilation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 1:30 PM, V2 stated R2 was on an antibiotic (ATB) when trying to schedule EGD appointment from 1/28/24 doctor's order but there is no documentation for this or for another appointment being scheduled within the 4 week time frame that was ordered. On 5/22/24 at 12:43 PM, V9 transport, stated she was in charge of making appointments for residents but it became too much due to so many transports. V9 stated V9 was not aware of R2 needing an appointment four weeks from R2's ED visit on 1/28/24. V9 stated sometimes V9 would get orders and sometimes V9 would not get orders especially if new nurses were working. The process for nurses includes stages such as checking medical orders, prescribing medications, and documenting executed orders. Ensuring the proper implementation of medical orders by nurses is essential for ensuring patient safety. Maintaining patient safety relies significantly on clear and carefully reviewed medical orders by nurses, serving as mechanisms to prevent practice errors. Incorrect implementation of medical orders poses a significant risk of severe harm to patients. BMC Nurs. 2024; 23: 113. Published online 2024 [DATE]. doi: 10.1186/s12912-024-01775-6

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35380 Based on interview and record review, the facility failed to provide appropriate fall interventions and keep equipment out of the hallways for one of three residents (R1) reviewed for falls on the sample list of 12 residents. Failing to ensure R1 was wearing appropriate footwear resulted in R1 falling and sustaining a laceration that required sutures. Findings include: R1's undated Cumulative Diagnosis Log documents R1's diagnoses as: Agitation due to Dementia, Major Neuro Cognitive Disorder, and Alzheimer's Disease probable with Behavioral Disturbances. R1's Nursing Admission Assessment documents R1 admitted to the facility on [DATE]. R1's Fall Risk assessment dated [DATE], documents R1 as a high fall risk. R1's Minimum Data Set, dated dated dated (MDS) dated [DATE], documents R1 has disorganized thinking and an altered level of consciousness. This same MDS documents R1 has had falls prior to admission to the facility. R1's Psychosocial assessment dated [DATE], documents R1 is easily distracted, is forgetful, has short and long term memory problems, wanders and paces, agitated, and has severe impairment with decision making and problem solving. R1's AIM (Assess, Intercommunicate, Manage) for Wellness report dated 4/28/24 at 10:30 AM, documents a crash was heard and down the hallway and R1 was lying next to a mechanical lift, R1 was on R1's right side, R1 sustained an abrasion to R1's right elbow. R1's Nursing Progress Note dated 4/28/24 at 12:30 PM, documents R1 has been up walking the halls. R1's AIM for Wellness report dated 4/28/24 at 4:00 PM, documents a witnessed fall. R1's Nursing Notes dates 4/28/24 at 6:20 PM, documents an order for blood draws and a urinalysis for repeated falls. R1's AIM for Wellness report dated 4/29/24 at 10:20 AM, documents R1 fell in the hall while ambulating independently, was not witnessed, assessed and found bleeding from a head injury and a small laceration on outer left eyebrow. This same report documents R1 was transported to the hospital. R1's Emergency Documentation notes dated 4/29/24, document a two centimeter linear laceration above the left eyebrow which was repaired with three sutures in the emergency room . R1's also had a diagnosis of a fall as a reason for this same visit. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan dated 5/1/24, documents the intervention for one fall on 4/28/24, to educate staff to keep hall clear and free of clutter; for the second fall on 4/28/24, to obtain a CMP (complete metabolic panel), CBC, (complete blood count) and a urinalysis (UA); for the fall on 4/29/24 to ensure appropriate footwear; and for a fall on 5/1/24, medication review requested. On 5/14/24 at 3:45 PM, V6 Licensed Practical Nurse (LPN) stated R1 wanders around the building. V6 stated R1 walks around a lot and wears gripper socks mostly during the evening and V6 does not know what other shoes R1 has. V6 stated that on 4/28/24, R1 was doing normal wondering and R1 was by the back door by the weight scale and one foot hanging off but R1 was trying to sit on the ground and lost her balance and fell on her bottom and was leaning over to R1's left elbow holding her up. On 5/14/24 at 1:22 PM, V3 Certified Nursing Assistant (CNA) stated R1 was walking like R1 normally does and she sometimes looks down when walking and we cue her to look up. V3 stated V3 passed R1 and was helping another resident and does not know if R1 had shoes on or what shoes they were. V3 stated R1 has slip on shoes and some slide sandals that are plastic and not safe to wear and there is no back on her shoes. On 5/14/24 1:40 PM, V1 Administrator stated R1 had a pair of sandals with a big wide band across the top and no straps in the back and a pair of slip on tennis shoes. On 5/14/24 at 3:15 PM, V5 Licensed Practical Nurse stated R1 has a pair of slip on tennis shoes with no laces and no back and a slipper sock thing with no back on it and it has a plastic sole. V5 stated R1 would be so tired from walking but would keep going that's when V5 thought R1's shoes might not be good. V5 stated she does not remember what if anything was on R1's feet when she fell that time. On 5/14/24 at 2:46 PM, V2 Director of Nursing (DON) stated R1 has a pair of tennis shoes which are slip-ons with no back and also wears a pair of yellow slippers with no back. V2 stated R1's husband was called after R1's fall from 4/29/24 so he could bring in another pair of shoes. V2 stated this was an intervention after that fall. V2 stated this should have been an earlier intervention because R1's shoes were not really safe. V2 stated R1 ran into a mechanical lift that was in the hallway on 4/28/24 which was not supposed to be there because it is a hazard. V2 stated the urine should have been obtained as soon as possible after the order was given since the order was given after the second fall on 4/28/24. V2 confirmed the order for a UA was given on 4/28/24 and was not obtained until 5/2/24. The facility's Fall Prevention Policy dated Revised 11/10/18, documents this policy is to provide for resident safety and to minimize injuries related to falls.