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	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casey Healthcare Center	100 N.E. 15th Casey, IL 62420

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 41970 Based on observation, interview, and record review the facility failed to provide supervision of a severely cognitively impaired resident, with a history of elopement, to prevent the resident from leaving the facility unnoticed and unattended. Due to R1's frontal lobe dementia, V20 physician stated (R1) could have been hit by a car, fallen and obtained a fracture, or been injured in a multitude of ways. This failure affects one (R1) of three residents reviewed for supervision. The immediate jeopardy began on 7/28/24 when R1 was allowed to leave the alarmed Dementia unit unsupervised resulting in R1 eloping 0.9 miles away from the facility. V1 Administrator was notified of the Immediate Jeopardy on 8/8/24 at 9:26 AM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on 8/8/24, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training through ongoing Quality Assurance Performance Improvement (QAPI) review. Findings include: R1 was admitted to facility on 3/14/24. R1's Electronic Medical Record (EMR) documents medical diagnoses as Dementia, Major Depressive Disorder, Altered Mental Status, Cognitive Decline, Colostomy Status and history of Cerebral Vascular Accident (CVA) and Chronic Ulcerative Enterocolitis. R1's admission Minimum Data Set (MDS) dated [DATE] documents R1 as severely cognitively impaired. This same MDS documents R1 as independent in transferring and ambulating. R1's Elopement Evaluation dated 3/21/24 documents R1 as high risk for elopement. R1's Social Service Progress Note dated 3/21/24 documents (R1) has a behavior of exit seeking but is able to be redirected. R1's Medical Record does not include any further social service progress notes. R1's Care Plan dated 3/25/24 documents R1 has wandering behavior and may demonstrate a risk for leaving unattended/elopement due to Altered Mental Status. R1's Care Plan documents an intervention dated 3/25/24 for R1 to have every 15 minute checks. R1's Care plan was first updated on 7/29/24 to include an intervention for staff to monitor R1 at all times when off the Dementia unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Physician Order Sheet (POS) dated August 2024 documents a physician order dated 7/29/24 of (R1) not to leave facility unless with staff or Power of Attorney (POA) for appointments per POA, (V17). This same POS documents a physician order to start Aspirin 81 milligrams (mg) daily. R1's Nurse Progress Notes document on: 3/23/24 at 9:45 PM (R1) exited the facility via the service door. (R1) was harder to redirect than the other four times. Semi combative. (R1) was assisted by staff to her room. 5/21/24 at 7:00 PM (R1) exit seeking. (R1) went out the front door and over by the trees on our property. Redirected back inside. 5/27/24 at 8:00 PM (R1) exited the building two times with more attempts. 6/1/24 at 6:50 PM (R1) exited out the Northwest service door. Easily re-directed back into the building. 6/16/24 at 'evenings' (R1) in and out of the South (Dementia) unit. (R1) did exit the building one time. 6/18/24 at 5:00 AM (R1) adamant to exit the south hall door. (R1) did get out the front door, exiting the building. (R1) is very swift. Escorted back inside with some difficulty. The facility Investigative Report of Missing Resident dated 7/29/24 documents R1 alert and oriented times one, ambulates independently and eloped from the facility on 7/28/24. This same report documents Family of (R1) called facility to notify (facility) of location (of R1). This same report documents R1 was found at V17 (R1's daughter) house. R1 left the facility unnoticed and unsupervised, at night, after dark in extreme heat and high humidity. R1 walked to a family member's house approximately 11 blocks (0.9) miles from the facility, crossing multiple streets, near a highway/culverts/guardrails/deep ditches. The public website titled www.timeanddate.com documents the high temperature for 7/28/24 was 85 degrees with 88% humidity. On 8/6/24 at 2:00 PM V15 Certified Nurse Aide (CNA) stated, I pushed the code into the door alarm on the Dementia Unit so that (R1) could go out into the main nursing home and sit on the couch. We (staff) do that all the time. I didn't know (R1) was supposed to be supervised when she was off the unit. (V16) CNA and I decided at around 7:30 PM that V16 CNA could go on lunch since it was so quiet on the hall. Right after (V16) left for break, residents started getting up and it became very busy. I didn't check on (R1) or let any other staff know she was sitting alone out there. I guess I should have. V15 stated when R1 returned to the Dementia unit, she continued to pace up and down the hallway. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/2/24 at 2:45 PM V10 Licensed Practical Nurse (LPN) stated R1 eloped from facility the evening of 7/28/24. V10 LPN stated R1 was sitting on a couch in the resident lounge area of the main nursing home about 7:30 PM prior to her eloping. V10 stated R1 resides on the alarmed Dementia unit and does occasionally wander through the main nursing home area unsupervised. V10 LPN stated V16 Certified Nurse Aide (CNA) had left the Dementia Unit at 7:30 PM and saw R1 sitting on the couch as she walked by to go to a break. V10 LPN stated it was reported to V10 that no other staff were present with R1 and that V16 did not stay with R1 nor report to anyone that R1 was not being monitored. V10 LPN stated R1 has a long history of 'escaping' the facility. V10 LPN stated R1 has been known to watch staff punch in the alarm codes, wait for the area to clear and then let herself out of the alarmed doors without the alarms sounding. V10 LPN stated the door alarms had not sounded that evening prior to R1 being reported as missing. V10 LPN stated, (R1) has eloped from the facility multiple times before 7/28/24 due to the lack of supervision and (R1) being very sneaky. V10 LPN stated, V16 CNA reported to V10 LPN at 8:30 PM that R1 could not be located. V10 LPN stated, I took off on foot looking around the outside of the building. It was so hot that night. It was dark out by the time we (facility) realized (R1) had eloped. There were dozens of people searching for (R1) including the police, emergency medical services (EMS), off duty facility staff, community neighbors and the facility staff. We (staff and volunteers) searched all over for her. I came across a couple walking their dog and they helped look for (R1) also. I walked about five blocks and then had to come back to the facility because it was miserably hot outside. My clothes were drenched. I don't know how (R1) ever made it as far as she did without passing out. (R1) had just gotten back from the hospital earlier that day for a Small Bowel Obstruction. (R1) was found by her family through (V17's) (R1's) family member's home camera system. (V17) notified the facility of (R1's) whereabouts and then we went to go pick her up. (V17) told us to hurry up and go get her because she was with (V18) (R1's) family member and (V18) did not know how to deal with (R1). (V17) stated 'you never know what (V18) will do'. I called (V2) Director of Nurses (DON) at 9:09 PM after (V17) reported (R1's) whereabouts and then (V2) and I went to get (R1). When (V2) Director of Nurses (DON) and I got to (V17's) house, (R1) looked hot and tired. (R1) looked exhausted. (R1's) face was red and somehow her colostomy bag had come off and she was just a mess with BM (bowel movement) all over her. On 8/6/24 at 9:30 AM V2 Director of Nurses (DON) stated R1 admitted to facility on 3/14/24. V2 DON stated R1 has exited the facility and left the property 'multiple times' prior to 7/28/24. V2 DON stated R1 was supposed to be on 15 minute checks since admission. V2 DON stated, I got the call from (V10) Licensed Practical Nurse (LPN) at 8:30 PM stating (R1) could not be located. We (facility) started a search throughout the building and could not find (R1). There were a lot of people out on the streets looking for (R1). (R1's) family (V17) was the one who called the facility and let us know where (R1) was. I believe (R1) was back inside the facility at 9:30 PM. Otherwise, we would still be looking for (R1). (R1) had left the building so many times before that night, I think she knew right where to go. V2 DON stated no resident should be allowed off the Dementia Unit without staff monitoring them. V2 DON stated, The reason why people have to stay back on the Dementia Unit is because they don't know any better. We (facility) are supposed to keep them safe. (R1) is a tough one because she is alert, ambulatory and determined to leave. (R1) gets physically aggressive when staff try to re-direct her but that is our (facility) problem to solve. We have to do better or (R1) is really going to get hurt. V2 DON stated R1's care plan had not been updated since her admission. V2 DON stated, We (facility) have talked about (R1's) exit seeking and previous elopements in morning meeting but that was never brought back to the staff. The staff rely on the care plan to be able to know what interventions to use. If the care plan is not updated, then the staff have to rely on word of mouth and that is not always accurate. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/6/24 at 10:20 AM V1 Administrator stated, (R1) has Frontal Lobe Dementia and really does not belong in our facility. (R1) is too much risk due to her being so mobile, having very poor safety awareness, Dementia and being sharp enough to be able to obtain the codes to the security doors on the Dementia unit. The night (7/28/24) (R1) eloped from the facility, R1 was sitting on the couch unattended by staff out in the main area of the nursing facility. We (facility) aren't even sure which door (R1) exited from. (R1) is quick. The staff had previously been in serviced on the need to always have two staff members on the Dementia unit at all times. That night there was one nurse (V10) Licensed Practical Nurse (LPN) and two (V15, V16) Certified Nurse Aides (CNA) on that unit. (V10) was on another hall and the two CNA's (V15, V16) were supposed to stay on the Dementia Unit. Apparently, V16 CNA left the hall to take a break which left V15 CNA on the hall by herself. That is when (R1) eloped. (R1) was supposed to be checked on every 15 minutes and wasn't. (R1) has been on 15 minute checks since she admitted . There is no reason my staff shouldn't have done those. (R1) gets confused every time she leaves the facility. (R1) had just came back from the hospital that day due to having a Small Bowel Obstruction. That paired with the fact that (V17) was on vacation, I think (R1) was even more adamant on leaving the facility. On 8/6/24 at 1:50 PM V20 Medical Director stated, There was failure from the facility to maintain the safety of (R1). The facility policies and Centers for Medicaid and Medicare Services (CMS) regulations were not followed. V20 stated, In a general statement, anything could have happened to (R1). (R1) could have been hit by a car, fallen and maybe obtained a fracture, or been injured in a multitude of ways. If there was adequate staff the night in question, the facility did not supervise (R1) as she needed to be and therefore (R1) eloped without the knowledge of the staff. On 8/7/24 at 1:40 PM V23 Nurse Practitioner stated, (R1) has a very specific type of Dementia with Frontal Lobe involvement. I have met with (R1) several times and can say that (R1) should not be allowed outside of the Dementia unit unsupervised. (R1's) Dementia would prevent her from being able to make safe decisions. (R1) should not be walking unsupervised off the facility property. (R1) has a higher risk than others due to her Dementia and impulsivity. V23 NP stated R1 is not able to make sound, safe decisions without the assistance of staff. V23 stated R1 could have been injured from falling, hit by a car, or tripped due to her shuffling fast pace. V23 NP stated R1 could have had heat related symptoms like a heat stroke due to her being unable to recognize those symptoms due to her Dementia. On 8/7/24 at 3:10 PM V24 Director of Psychiatry program for facility stated V24 is familiar with R1. V24 stated R1 should never be allowed to be unsupervised when out of the alarmed Dementia Unit. V24 stated, There are not only environmental factors that (R1) may be injured from while walking outside of the Dementia Unit but (R1) has what you call 'excitable agitation.' (R1) has increased agitation with verbal and physical aggressive behaviors when anyone attempts to redirect (R1). If (R1) were out in the community by herself and came across another person who attempted to redirect (R1) that would most likely agitate (R1) and the other person may respond negatively to that interaction possible creating harm for (R1) from a physical altercation. (R1) has impulsivity along with very poor judgement and decision making efforts. (R1) thinks like a small child with no impulse control. (R1) would have significant risk of harm due to her aggressive behaviors related to her Dementia. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/2/24 at 1:10 PM V9 (R1) Power of Attorney (POA) stated R1 left the faciity on [DATE] without any staff aware of her elopement. V9 POA stated, My other sister (V17) lives about a mile from the facility. (V17) normally visits regularly and takes (R1) back to her house. (V17) has cameras at her house and that is how we found (R1). (V17) saw (R1) on the front porch of (V17's) house. (V17) then called (V18) (R1's) family member to go over to (V17's) house and I called (V10) Licensed Practical Nurse (LPN) to let the facility know where (R1) was. I don't believe (R1) was badly hurt at all. (R1) has escaped that facility lots of times but this is the furthest she has gone. I don't know what we are going to do with (R1). The staff know (R1) leaves all the time and can't seem to stop her. Maybe they (staff) need more training or something. They (staff) are trying but I want (R1) to be safe too. On 8/2/24 at 10:25 AM V7 Maintenance Director stated the alarms are not checked on the weekends so there is no way to know if the alarms were working on the weekend R1 eloped from facility. On 8/2/24 at 2:06 PM V14 Certified Nurse Aide (CNA) stated, (R1) tried to leave the unit all the time. (R1) sits out in the main resident lounge area off the Dementia unit. The staff out there are supposed to keep an eye on her. I don't know how much good that does since (R1) knows the codes to the doors. On 8/2/24 at 10:17 AM R1 was walking up and down the hallway on the Dementia unit. R1's room is located at the end of the hall directly next to the exit door. R1 walked up to exit door on the Dementia unit and attempted to push the door open. On 8/6/24 at 11:30 AM R1 was pacing the hall of the Dementia Unit. R1 pushed another resident in a wheelchair out of her way to get to the exit door. R1 opened the exit door slightly as staff redirected R1 away from the door. On 8/7/24 at 2:25 PM R1 pushed a heavy wooden chair out of her way in the hallway to walk up to the exit door on the Dementia Unit. R1 attempted to open the door as staff redirected R1. The Immediate Jeopardy that began on 7/28/24 and was removed on 8/8/24 when the facility took the following actions to remove the immediacy. 1. R1's Care Plan was reviewed by the Interdisciplinary Team (IDT) on 8/8/24. On 8/9/24 V8 Resident Care Coordinator (RCC)/Licensed Practical Nurse (LPN) stated the IDT team reviewed and updated R1's care plan and added new interventions to aide in preventing R1 from eloping from the facility again. V8 stated she had a direct role in updating R1's Care Plan. 2. V1 Administrator stated all staff present in facility were in serviced on R1's updated elopement preventions on 8/8/24. 3. The Facility Elopement Policy, Missing Resident and Door Alarm Policy were reviewed by V26 Director of Clinical Operations. V26 stated on 8/12/24 that the facility policies were reviewed on 8/8/24 and were in compliance with state and federal regulations. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. All staff will have access to and review a communication binder at the beginning of their shift for any safety intervention updates. V8 RCC/LPN stated on 8/9/24 the communication binder was implemented on 8/8/24 and is a new intervention to inform staff of any changes with residents at risk for elopement. V8 RCC/LPN stated V8 will take the communication binder to all Quality Assurance meetings Monday through Friday for the IDT team to review and update. V8 RCC/LPN stated the communication binder will be updated on the weekends through the on call nurse if necessary. 5. V1 Administrator initiated an in-service with all staff in the facility on 8/8/24. Elopement Policy, Missing Resident Policy, Door Alarm Policy, Communication Binder, Dementia Care Policy were included in this in-service. V1 stated the staff present were instructed that safety interventions to prevent elopement must be followed. V1 Administrator stated on 8/9/24 that any staff not present for the in servicing on 8/8/24 will be in-serviced prior to the beginning of their next scheduled shift. V2 DON stated the new hire staff will be trained during orientation through the new employee packet. Any other PRN (as needed) staff, agency staff or staff that have not worked yet will be in serviced. V2 DON will train nurses and V21 will train new hire CNA's. V2 DON stated the department manager will complete the training for any new hire staff for their own departments. 6. V8 RCC/LPN stated V8 initiated chart reviews and updating care plans on 8/8/24 and V8 completed all chart reviews and updated care plans for all residents at risk for elopement on 8/9/24. 7. All exit doors and devices were assessed on 8/8/24 by V7 Maintenance Director. V7 Maintenance Director stated on 8/8/24 that all exit doors and any existing alarms were checked, and all were functioning properly. V7 stated V7 will continue to check all the exit doors and alarms through the week and the on call nurse will check them on the weekends. 8. The elopement binder was reviewed and updated on 8/8/24. V12 Social Service Director (SSD) stated V12 will update the elopement binder with each new admission. V12 stated V12 takes the resident's picture and fill out the elopement resident details form. V12 stated she reviewed the elopement binder on 8/8/24 and found no issues. 9. The IDT team will ensure current safety interventions are being followed for their assigned residents. V1 Administrator stated these audits will occur three times per week for four weeks. V1 stated the IDT team was instructed to report any concerns to V1 Administrator and/or V2 Director of Nurses (DON) for corrective action if necessary. 10. V1 Administrator will perform a drill to determine the effectiveness of staff training on the Elopement Policy, Missing Person Policy and Door Alarm Policy, on random days and different shifts four times in one month. Any concerns identified following the drills will be immediately addressed through additional education by V1 Administrator. V1 stated the facility will have drills starting next week. 11. V7 Maintenance Director stated V7 will continue to check all the exit doors and alarms through the week. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12. The on call nurse will check the exit doors, alarms and devices on the weekends. V7 Maintenance Director stated any problems with the exit doors, alarms or devices will be reported to V1 Administrator. V4 Dietary Manager confirmed that all the exit doors and alarms were functioning properly on 8/10/24 and 8/11/24 during weekend rounds. V8 RCC/LPN confirmed that resident exit alert devices were functioning properly on 8/10/24 and 8/11/24 during resident device checks done by nursing staff and V8. 13. The communication binder will be reviewed twice weekly by V1 Administrator and/or V2 Director of Nurses. V1 Administrator stated this audit has been initiated and will be ongoing for the remainder of the month. V1 Administrator stated V1 reviewed the binder on 8/8/24 prior to putting the binders on the nurses stations. 14. Residents at risk for elopement will be reviewed weekly during Quality Assurance (QA) meetings. V1 Administrator stated the facility began on 8/8/24 to review all residents at risk for elopement and finished the initial review on 8/9/24. V1 stated the elopement binder was reviewed on 8/9/24 and will be updated with any change of status for existing residents and updated with any new information for new residents. 15. All action plans will be reviewed weekly for four weeks by the Quality Assurance Team. V1 stated if there are any concerns or noncompliance, the QA team led by V1 Administrator will resolve any issues immediately. The facility presented an abatement plan to remove the immediacy on 8/8/24. The survey team reviewed the abatement plan and was unable to accept the plan to remove the immediacy. The abatement plan was returned to the facility two separate times on 8/8/24 for revisions. The facility presented revised abatement plans on 8/8/24 and the survey team accepted the abatement plan on 8/8/24.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 41970 Based on interview and record review the facility failed to provide in servicing to staff members on the facility Quality Assurance Performance Improvement (QAPI) program. This failure has the potential to affect all 44 residents residing in facility. Findings include: The facility Daily Midnight Census dated 8/2/24 documents 44 residents residing in the facility. The undated facility Quality Assurance Performance Improvement (QAPI) Solution Revolution Policy documents QAPI includes all employees, all departments and all services provided. The facility educates staff on intervention and anticipation of resident's needs. A facility wide training will be conducted to inform everyone in the facility about the QAPI plan. These trainings will be conducted often and in multiple ways through regular all-staff meetings, department staff in-services, change of shifts report time. Dialogue, examples, exercise, etc. On 8/7/24 at 10:00 AM V22 Registered Nurse (RN) stated V22 has not received any training on the Quality Assurance Performance Improvement (QAPI) process. V22 RN stated, I think that is something the managers do but I really don't know. I haven't had any kind of training on that. On 8/7/24 at 1:40 PM V25 Certified Nurse Aide (CNA) stated V25 has not received any training on QAPI. V25 CNA stated, I have never heard of that. On 8/9/24 at 1:45 PM V19 Certified Nurse Aide (CNA) stated V19 has not received any QAPI program training. On 8/9/24 at 9:26 AM V1 Administrator stated the facility management team including the Medical Director has QAPI meetings at least quarterly. V1 stated the information brought back to the staff is by word of mouth. V1 stated, Apparently we (facility) are not educating the staff on new interventions for residents or any updates to policies or processes. If our staff do not know what those updates are, they will never be implemented.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41970 Based on interview and record review the facility failed to provide twelve hours of mandatory training for Certified Nurse Aides (CNA) yearly. This failure has the potential to affect all 44 residents residing in facility. Findings include: The facility Daily Midnight Census dated 8/2/24 documents 44 residents residing in facility. The facility Inservice Attendance sheets dated August 2023 through August 2024 do not document V27, V28, V29, V30 and V31 Certified Nurse Aide (CNA) have completed twelve hours of mandatory training. The facility provided documentation of employee hire dates and in-services documents the following: V27 Certified Nurse Aide (CNA) was hired on 5/25/2022 and has completed six hours of in-services in the past twelve months. V28 CNA was hired on 10/25/22 and has completed six hours of in-services in the past twelve months. V29 CNA was hired on 9/12/22 and has completed four hours of in-services in the past twelve months. V30 CNA was hired on 9/7/1994 and has completed eight hours of in-services in the past twelve months. V31 CNA was hired on 9/1/22 and has completed five hours of in-services in the past twelve months. On 8/13/24 at 3:00 PM V21 Lead Certified Nurse Aide (CNA) stated all CNA staff should have twelve hours of training every year. V21 stated the trainings are provided by the facility and anyone not present should be receiving the education. V21 stated V21 cannot provide documentation of in-services for V27, V28, V29, V30 and V31.