| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146117 | A. Building<br>B. Wing | 05/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Casey Rehab and Nursing | 100 N.E. 15th<br>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) |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50322<br><br>Based on observation, interview, and record review the facility failed to ensure fall interventions were implemented for one (R2) of three residents reviewed for accidents on a sample list of three residents.<br><br>Findings Include:<br><br>R2's undated care plan documents R2's medical diagnoses include dementia with agitation, delusional disorders, essential hypertension, spinal stenosis, lumbar region without neurogenic claudication, vitamin B12 deficiency anemia, anxiety disorder, other malaise, urinary tract infection, depression, and psychotic disturbance.<br><br>R2's undated Care Plan includes fall interventions actively in place as Call Don't Fall sign visible in room, toilet every hour, non-slip strips in front of toilet, scoop mattress, non-slip strips next to bed, non-slip material to recliner and wheelchair seat, 15-minute wellness checks, therapy to screen for services, non-slip strips in front of recliner, Certified Nursing Aide (CNA) to assist to bed at 9:00 pm, and move R2's room closer to nurse station.<br><br>R2's Visual Bedside Kardex, undated, documents R2 is to have non-skid socks or appropriate footwear at all times, 15-minute safety checks, offer bathroom assistance every hour, maximum assistance with bed mobility and transfers, and all laboratory results to be monitored per physician order.<br><br>R2's Minimum Data Set (MDS) dated [DATE] documents moderate cognitive impairment with hallucinations, delusions, impaired decision making, sundowning behaviors, non-compliance, and short-term memory loss. The MDS also documents R2 frequently refuses cares and has wandering behaviors. Section GG documents toileting activity requires substantial/maximum assist and R2 has frequent incontinence.<br><br>R2's individual fall log, undated, documents R2 sustained falls on 3/2/25, 3/20/25, 3/22/25, 3/27/25, 4/6/25, 5/5/25, 5/15/25, 5/18/25, and 5/24/25.<br><br>R2's Nurse Progress Notes document on 5/5/25 R2 was found on the floor in front of the recliner and R2 stated the recliner threw her out. On 5/6/25 R2's Care Plan, undated, documents the new intervention to add non-slip strips in front of the recliner.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R2's May 2025 Progress Notes document on 5/14/25 staff reported R2 had two plus pitting edema to R2's bilateral lower extremities and 11 hours later at 12:30am on 5/15/25, R2 was found in front of the recliner on the floor in R2's room with R2 stating she was trying to go brush her teeth and use toilet. The Progress Notes document the nurse practitioner was notified and the new intervention to have Certified Nursing Assistant (CNA) assist R2 to bed at 9:00pm every night.<br><br>R2's Nursing Progress Notes dated 5/18/25 document R2 was screaming for help and was found on the floor next to the bedside table in front of the recliner in R2's room with R2 stating she was trying to go use toilet. On 5/20/25 R2's Care Plan, undated, documents the new intervention to move R2 closer to nurse's station.<br><br>R2's Nurse Practitioner Visit Note dated 5/19/25 documents R2 had a recent unwitnessed fall and documents a diagnosis of hyponatremia and new order for a blood test on 5/22/25.<br><br>R2's Physician Order Sheet (POS) dated 5/28/25 documents an order for a blood Basic Metabolic Panel (BMP) on 5/22/25. R2's Medication Administration Record for May 2025 documents the order for the BMP was not completed. R2's medical record does not document the CMP was completed or that the physician was notified.<br><br>R2's medical record does not document hourly toileting.<br><br>R2's Point of Care (POC)15-minute check log dated 5/15/25 - 5/28/25 does not document ordered safety checks every 15 minutes.<br><br>On 5/28/25 between 11:00am and 12:00pm continuous observation of R2's room entrance and hallway were completed. At no time was staff observed entering R2's room to complete 15-minute safety checks.<br><br>On 5/28/25 at 12:35 pm R2 was in the wheelchair in front of the recliner in the room with the bedside table on the left of R2. There was no Call Don't Fall sign in the room. R2's Recliner and wheelchair seat did not have non-slip material in the seat. Non-slip strips were not present on the bathroom floor and the toilet paper holder was broken and hanging off the wall.<br><br>On 5/28/25 at 12:35 pm R2 stated she currently has no pain but does have episodes of pain stating, of course I have pain from falling all over these floors!' R2 stated she recalls falling in the bathroom a few days ago and confirmed breaking the toilet paper holder. R2 stated she needs to have shoes on all the time, so she doesn't fall. During conversation R2 was rolling the wheelchair back and forth with the brakes in the locked position. R2 demonstrated locking and unlocking the brakes and in both settings. R2 was able to move freely in the wheelchair.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/28/25 at 1:40 PM V2 Director of Nurses verified that 15-minute checks were not being accurately documented. V2 stated tomorrow on 5/29/25, R2 will be moved to the dementia unit for better observation of the resident. V2 stated she is unclear why there are no non-slip strips on the bathroom floor as she was sure they were there last Friday 5/23/25. V2 stated she's unsure why R2 doesn't have non-slip material in the wheelchair and recliner. Regarding the BMP blood test for R2, V2 stated the nurse checked off the test on the MAR on 5/21/25 as not obtained and therefore the test was not completed. V2 verified no follow up or provider notification of the missed blood test was completed. V2 agreed that R2's change of condition on 5/14/25 could have contributed to R2's early morning fall on 5/15/25 and that the order given by the nurse practitioner for blood testing was to diagnosis any new medical issues related to the change of condition.<br><br>The facility policy titled Fall Reduction Prevention dated 10/30/24 documents the purpose is to provide an environment that remains as free of accident hazards as possible and to identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries. The policy states all witnessed, unwitnessed and any near falls should be investigated. Resident should be evaluated for change in condition and provider notification should be completed. Current fall prevention interventions should be evaluated, and new interventions should be initiated. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>40385<br><br>Based on interview and record review the facility failed to timely initiate antibiotic treatment for a urinary tract infection for one of three (R3) residents reviewed for falls in the sample list of three.<br><br>Findings include:<br><br>R3's Nursing Note dated 3/31/2025 at 10:55 AM documents R3 continued post fall monitoring with increased weakness and lethargy noted. R3's urostomy was draining dark amber, slightly cloudy urine. V3 Nurse Practitioner was notified, and new orders received.<br><br>R3's Physician Order dated 3/31/25 documents to obtain urinalysis and culture if indicated. R3's urinalysis and culture with print date 4/5/25 documents leukocyte esterase (white blood cell enzyme) 3+ (normal is negative), white blood cells 10-15 (normal is 0-5), and few bacteria, mucus and white blood cell clumps (all abnormal). These results document greater than 100,000 colony forming units per milliliter (cfu/ml) of mixed bacterial flora with multiple species present and recommends a repeat sample collection if indicated.<br><br>R3's urinalysis and culture, with print date of 4/9/25, documents leukocytes esterase 4+, white blood cells 20-30, and moderate bacteria and white blood cell clumps. These results document greater than 100,000 cfu/ml of mixed bacterial flora with multiple species present.<br><br>R3's Progress Note dated 4/10/25, recorded by V3, documents R3 was evaluated due to staff request for increased confusion and urine sent to lab. This note documents an order for Augmentin 500-125 milligrams (mg) by mouth twice daily for seven days for urinary tract infection. R3's Physician Orders dated 4/10/25 and 4/11/25 document to administer Augmentin 500-125 mg by mouth twice daily for seven days. R3's April 2025 Medication Administration Record documents Augmentin was not started until 4/12/25 at 8:00 AM.<br><br>R3's Nursing Note dated 4/11/2025 at 8:55 PM documents R3's ordered antibiotic was not available in the facility's backup medication system, the pharmacy was notified and verified the medication would be sent to the facility. R3's nursing notes do not document V3 was notified of the delay in starting R3's antibiotic.<br><br>The facility's Inventory on Hand (backup medication system) documents Augmentin is supplied in 875-125 mg tablets, and not in 500-125 mg tablets.<br><br>On 5/28/25 at 11:16 AM V2 Director of Nursing stated R3's 4/9/25 urinalysis results were reported to V3 on 4/9/25 through (messaging software), and V3 saw R3 on 4/10/25 and ordered Augmentin. V2 stated the 500 mg dose was not supplied in the facility's backup medication system, so the medication was not started until 4/12/25 when the medication arrived from the pharmacy. V2 stated the facility has a backup pharmacy system, and staff should notify the facility's pharmacy who contacts a backup pharmacy to supply the medication. At 12:34 PM V2 stated physician notification is documented in the nursing notes, including when a medication is not given.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/28/25 at 12:09 PM V3 stated V3 rounded in the facility weekly on Thursdays and antibiotics should be implemented by the next morning, or that evening if the facility has the medication in the back up medication system. V3 stated the pharmacy should have delivered R3's Augmentin that night so that it could be started the next morning. V3 stated if the facility would have reported the medication dose was not available. V3 would have given additional orders and asked what dose the facility had on hand.<br><br>The facility's undated pharmacy guide, titled What to Do If a Medication is Not Available during a Med Pass documents the following: Verify/review pharmacy deliveries. Check the backup medication system for the medication, remove dose, and administer to the resident. If the medication is not available, check to see if there is an alternative medication that can be given with a physician's order. If the medication is not located or unavailable in the backup supply, notify the pharmacy to request delivery from a backup pharmacy and verify the medication will be sent out on the next pharmacy delivery. Notify the provider that the medication was not available to administer as ordered/scheduled and request an order to hold the medication until delivery from pharmacy. These steps will avoid the need to document that medications are not available, will ensure residents receive medications timely, will avoid further potential delay in treatment. |